Nebraska Jurisdictional Plan 2012

Nebraska Department of Health and Human Services

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"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity of socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

National HIV/AIDS Strategy Vision

Introduction

The nation's HIV prevention efforts are guided by a single, ambitious strategy: the National HIV/AIDS Strategy (NHAS). Recent scientific breakthroughs have equipped us with an unprecedented number of effective tools to prevent infection and improve health outcomes for those infected with HIV.

However, challenges still remain. New infections *are* occurring and people infected with HIV are living longer. As a result, the number of people living with HIV in Nebraska continues to grow, creating the potential for more opportunities for HIV transmission. A range of social, economic, and demographic factors affect some Nebraskans' risk for HIV, such as stigma, discrimination, income, education, and geographic region of the state. While current prevention efforts have helped to keep the number of new infections stable in recent years, continued growth in the population living with HIV will ultimately lead to new infections if prevention, care, and treatment efforts are not intensified.

To address these challenges, the Center for Disease Control and Prevention (CDC) and its partners are pursuing a High-Impact Prevention approach to reducing new HIV infections. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of HIV Prevention efforts – an essential step in achieving the goals for NHAS and for Nebraska.

In addition to the focus on High-Impact Prevention activities, CDC has recently establish new priorities for directing resources to the geographic areas where the greatest impact on HIV rates can be achieved. This includes a new approach to health department funding and expanded HIV testing efforts. For Nebraska, a low-incidence state, this means a significant reduction in the funding level received from CDC and a clear directive to intensify education, testing, and linkage to care efforts. It is a classic case of, "Do more with less."

This Jurisdictional Plan is a written statement of need for the state of Nebraska. It has been developed through a collaborative process with local prevention, care, and treatment providers and stakeholders. The Jurisdictional Plan describes current resources, needs, and gaps for HIV prevention services in the state. It also provides information on how Nebraska can work to meet the goals of NHAS. It will take the renewed commitment of all of us to meet today's challenges in HIV prevention and care, but together, it is a challenge we are well-equipped to meet.

Epidemiological Background

HIV/AIDS

This summary describes the trends seen in HIV Disease cases (includes HIV only, AIDS cases, and cases who were initially diagnosed with HIV then became AIDS). The source of data is the Nebraska Department of Health and Human Services HIV Surveillance Program, which is responsible for collecting data on all cases of HIV Disease in Nebraska. AIDS was first reported in 1983 and HIV named reporting began in July 1995 in Nebraska. A comprehensive review of HIV disease can be found in the 2012 Epi Profile (See Appendix).

HIV/AIDS Incidence: At of the end of 2010, a total of 2,594 persons had been reported with HIV Disease in Nebraska. Of these, 859 (33%) were known to have died. During 2010, 108 new cases of HIV Disease were diagnosed reflecting an incidence rate of 5.9 cases per 100,000 population.
The number of HIV Disease cases increased from 3 cases in 1983 to 131 cases in 2001, the highest number of cases diagnosed in one year in Nebraska. Then the number of cases per year decreased steeply to 75 cases in 2003, increased to 116 cases in 2005 before dropping to 108 cases diagnosed in 2010.

Trends Among Cases Diagnosed Cases: 2006 to 2010*:*
The number of HIV Disease cases diagnosed within this time period was relatively stable: 110 cases diagnosed in 2006 and 108 cases diagnosed in 2010.

The trends among males and females remained stable during this time period. Among males newly diagnosed, which represented 74% of all cases during this time period, 85 cases in were identified in 2006 compared to 83 cases in 2010. Female cases represented 26% of all the cases and 25 cases were diagnosed in both 2006 and 2010. There was a peak of 38 female cases in 2009. The overall ratio of males to females was 2.8:1.

By age group, the 25-44 year olds represented 61% of all the cases. The trend for this group tended to decline slightly from 2006 when 74 cases were diagnosed to 58 cases in 2010. The trend for the 45-64 year olds and the 13-24 year olds was fairly stable and overlaid each other on a chart. The 45-64 year olds went from 20 cases in 2006 to 24 cases in 2010. The 13-24 year old cases went from 15 cases in 2006 to 25 cases in 2010, perhaps the beginning of an upward trend.

Whites represented 55% of those diagnosed in 2010 and the trend was stable from 2006 to 2010, from 54 cases to 59 cases, demonstrating a slight upward trend. The number of Blacks represented 31% in 2010 and has also remained stable, from 40 cases in 2006 to 34 cases in 2010, a slight downward trend. There was a slight peak in cases in 2008 for both Blacks and Whites, 58 cases for Whites and 40 cases in Blacks. The difference in the number of cases diagnosed between these two races that year was only 20 cases. In 2010, the difference in cases between Blacks and Whites had become wider at 25 cases.
Note: Rates for race/ethnicities are calculated by the number of HIV Disease Cases divided by their population in the 2010 census multiplied by 100,000, to allow for comparison between race/ethnicities when the population of each race/ethnicity varies so widely, which is the case for Nebraska*.*

Rates for newly diagnosed HIV Disease cases were highest for Blacks and lowest for whites. The rate in 2006 for whites was 3.6 per 100,000, while Blacks had a rate of 54.9 per 100,000, even though the number of white HIV cases was 54, and the number of Black HIV cases was 40. The rate for Black HIV cases in 2010 was 46.7 per 100,000 while the number of Black HIV cases was 34. In comparison, the rate for whites in 2010

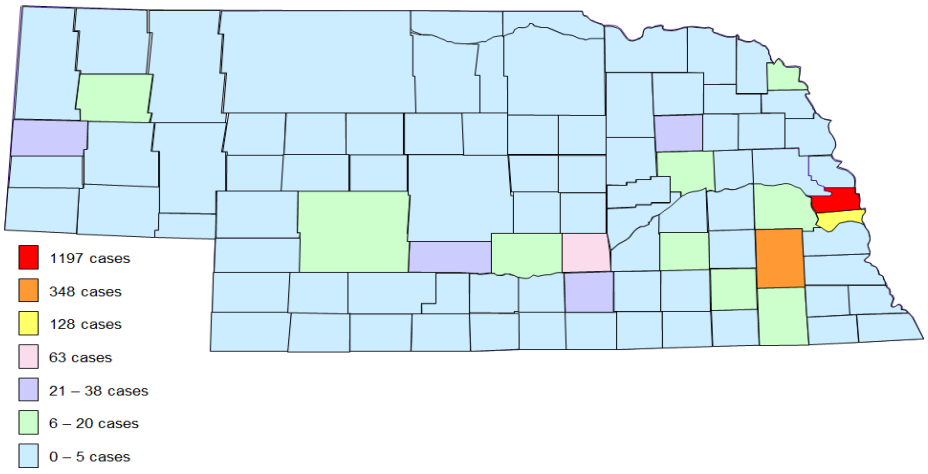
was 3.9 per 100,000 and the number of HIV cases was 59. The trend in the rates for both Blacks and whites stayed stable through 2006 to 2010. The rate for Hispanic cases was as low as for whites, yet the number of cases for Hispanics ranged from 1 to 3 times higher than for white cases.

Among men, the most commonly reported risk was men who have sex with other men (MSM; 57%), Heterosexual contact with a person known to be at risk for HIV infection, injection drug use (IDU), and MSM with IDU were all near 6%. Among women, heterosexual contact was reported for 70% of the cases (presumed heterosexual females were included in the heterosexual category), and 6% reported injecting drug use as their risk exposure.

Prevalence: At the end of 2010, 1,737 Nebraska residents were known to be living with HIV/AIDS (PLWHA). However, since not all persons infected with HIV are aware of their status, it is estimated that there were between 2,073 and 3,109 persons currently living in Nebraska with HIV disease. The majority of PLWHA live in Douglas County (59%) and Lancaster County (18%). In the time period of 2006 to 2010, the majority of the living HIV Disease cases were males, who represented 74% of the cases. White living HIV cases were the majority of race/ethnicities at 51%. The age group 25 to 44 years of age was the largest at 62%. The major risk behavior for men in this age group was men who have sex with men at 42%. For women, heterosexual contact was the major risk behavior.

Number of Living* Cases of HIV Disease, by County of Current Residence, through December 2011, Nebraska

N = 2,106



*Living cases = vital status is either alive or unknown.

Nebraska HIV Surveillance Program, February 2012

MSA with at least 30% PLWA

There are 3 Metropolitan Statistical Areas (MSA) in Nebraska, according to the US Census Bureau based on the 2006 population of Nebraska. The definition of an MSA is having at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration. They are: Omaha-Council Bluffs, Lincoln-Seward, and Sioux City, Iowa. The Omaha-Council Bluffs MSA includes these Nebraska counties: Douglas County, Sarpy County, Cass County, Saunders County, and Washington County, and these counties in Iowa: Pottawattamie, Harrison, and Mills Counties. The Omaha-Council Bluffs MSA area has a total population of 849,517. If only the Nebraska counties are used for the MSA, the Omaha metropolitan area has a population of 737,162. Douglas County by itself has a population of 492,003. The

Lincoln-Seward MSA includes Lancaster County and Seward County. The total population for this MSA equals 283,970. The third MSA, Sioux City-Vermillion includes counties from Iowa, Nebraska, and South Dakota. The counties in Nebraska that belong to this MSA are Dakota County and Dixon County. The total population on the Nebraska side equals 26,587, which does not meet the definition for an MSA in Nebraska. The largest number of PLWA through 2010 live in the Omaha MSA: 1,141 HIV Disease cases. This number represents ***65.8% of all living HIV Disease cases in Nebraska.***

Highest risk populations
(All the data for this section is based on all the HIV Disease Cases diagnosed from 2006 to 2010.) MSM is the risk of most concern, since they represent 225 (42%) of all cases in the state, and 57% of all the male cases. The majority of MSMs in the state are White, with 157 cases (70%), while Blacks numbered 41(18%), and Hispanics had 18 cases (8%).

The second most common risk behavior in the state is Heterosexual Contact. They represented 123 (23%) of all risk behaviors when female presumed heterosexual cases are included in this category. For females, heterosexual contact is the largest risk behavior at 97 cases or 70% of all the female cases in the state. Heterosexual contact for men represents 26 cases or 32%.

Other risk behaviors of interest are the Adult MSM/IDU, which only represent 5% of all the cases among males. Injection drug use is also low in the state: 31 cases (6%) which include males and females. Injecting Drug Use (IDU) amounts to only 6.5% of all female risk behaviors and 5.6% of all the male cases.

Since the Omaha MSA is the largest of all the MSAs, the focus is on the largest risk which is MSM and represents 148 (58%) among males. MSMs in this group are mainly white (91 cases, 63%), while Blacks represent 36 cases (25%) and Hispanics numbered 12 cases or 8%.

The next highest risk in the Omaha MSA is Heterosexual contact. They represent 25% of all the cases. Among females, they represent 74% of the 98 females. For males, they represent 6% of all the 255 cases. The majority of the Female heterosexual contact cases are Black (59%), while whites made up 29% of these cases.

In summary, the focus for prevention efforts is MSMs for men in the Omaha MSA, which should include white, black, and Hispanic men. Prevention efforts for females should focus mainly on heterosexual cases, both Whites and Blacks.

Spotlight on Social Determinants in Douglas County:

The Poverty rate in Douglas County, for those 25 years of age and over and determined by education attainment, is the highest (22%) for those who have less than a high school degree. The poverty rates for those who were high school graduates were 12%. The poverty rates were higher for females than for males. For females with less than a high school degree, the percentage of poverty was 29%, while for males 17%.

Educational Attainment for 18 to 24 year olds is 17% for those with less than a high school graduate, and 27% for those with were high school graduates (including those with GEDs). For the 25 year olds and over, 25% have high school diplomas, and 23% had some college, but no degree. For those 25 to 34 years old, 90% have a high school diplomas, and 39% have a Bachelor's degree or higher.

The total median earnings in the past 12 months for all 25 year olds and over was 33,433. For those who had less than a high school diploma, earnings were $20,645. Males earned more than females, $23,087

compared to $16,497. The total for those who had a high school diploma was $26,105. Males earned more than females in this group. The median earnings for males in this group were $30,060 and for females were $21,234.

Race/ethnicities: The population for Douglas County is primarily white (312,280), then Black (38,841), and Hispanic (29,194).

Employment Status: For those who are 16 years old and over, 72% were in the labor force, 67% were employed, and the unemployment rate was 6.3%. The percentage of Whites who were in the Labor Force was 73%, while for Blacks, the percentage was 67%.
For those who were employed, 69% were white, while 56% were Black. For those who were unemployed, 4.8% were white, but Blacks had the highest number of unemployed, at 17.6%

Fertility: The percent of women, who had a birth in the past 12 months, were unmarried and whose income was less than 100 percent of the poverty level was **80%.** For those who were determined to be at the 100 to 199 percent of the poverty level, the percent of women who had a birth and were unmarried was 33%.

Characteristics of Teenagers, 15 to 19 years old: The total number of teens who enrolled in school was 29,749, and 3,974 were not enrolled in school. By race, there were 1,908 white teens not in school and blacks had 930 teens not in school with the number of Hispanic teens not in school at 901.
The percentage of females who had a birth in the past 12 months was 2%. By race, white females represented 0.6%, while Blacks came in at 8% and Hispanic females 2%.

Youth Risk Behaviors

The 2010 Youth Risk Behavior Survey (YRBS) was completed by 3832 students in 72 public high schools in Nebraska during the fall of 2010. The school response rate was 91%, the student response rate was 72%, and the overall response rate was 66%. The results are representative of all students in grades 9-12. The survey shows that Nebraska youth are sexually active, with over 50% reporting sexual activity by the end of 12th grade. Approximately 20% of these youth drank alcohol or used drugs before their last sexual intercourse, while only 62% used a condom. This data confirms that Nebraska youth need access to accurate and appropriate prevention services.

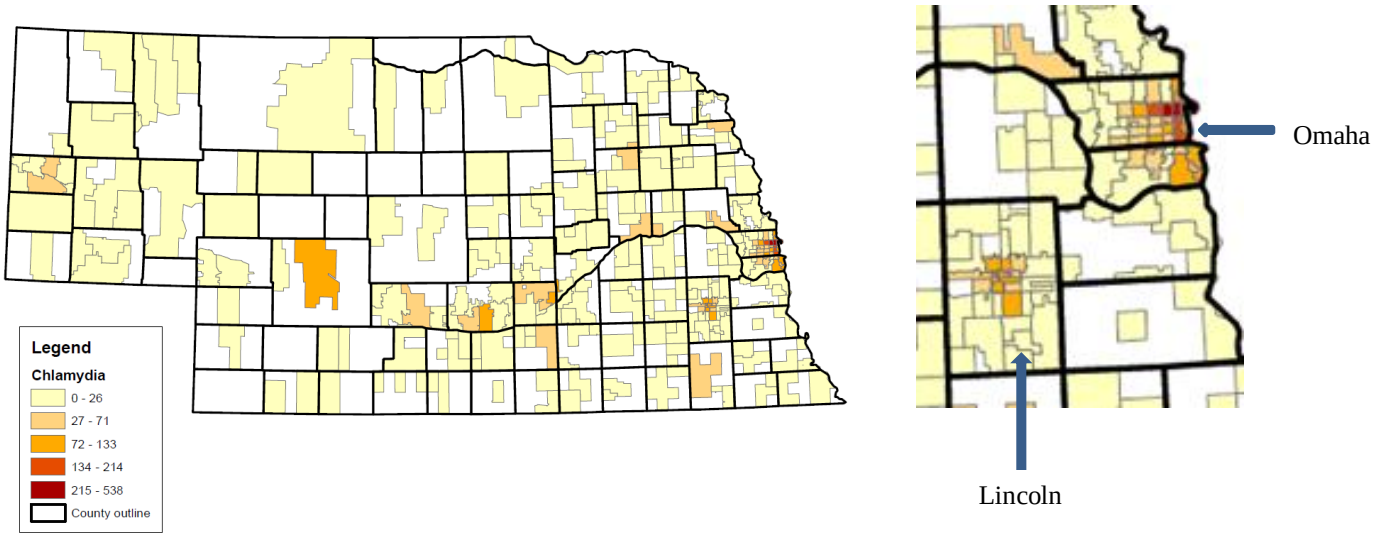
Chlamydia

Chlamydia testing began in Nebraska in 1992, and at that time focused only on childbearing female's ages 15-44 years. Symptoms of chlamydia can be mild or even asymptomatic but when present they can cause pain, breakthrough bleeding, swelling, and leave scar tissue which can lead to infertility.

Current screening guidelines for chlamydia screening Nebraska Infertility Prevention Project (NIPP) are:

1. All clients attending Family Planning clinics
2. All females ages 15-24 years
3. All females ages 25-29 with one or the following risk factors:
    a. New partner or multiple partners in the past 90 days
    b. Recent contact to an STD
    c. Symptoms suggesting an STD

Number of Chlamydia Cases by Zip Code, 2011



In 2011, the Nebraska STD program screened 33,708 individuals**,** which is a 22% increase from 2010 with 87 of 93 counties reporting at least one positive case.

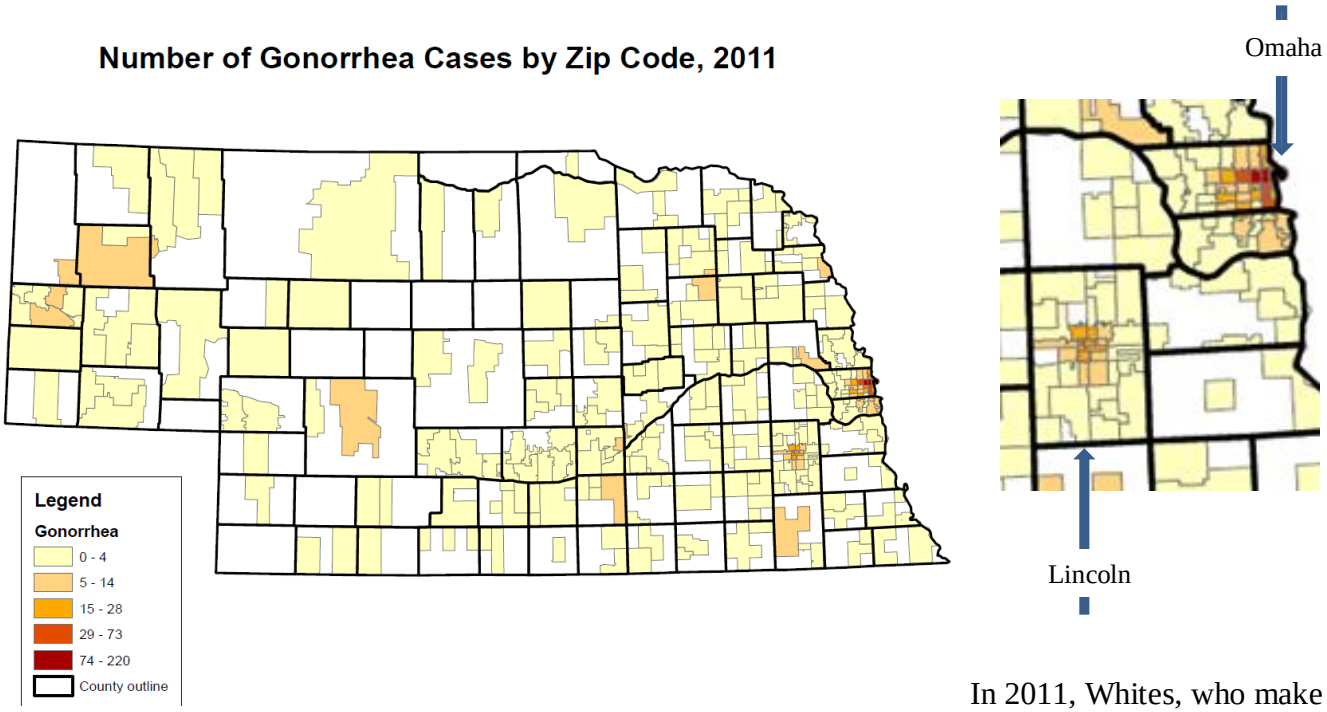
The number of reported Chlamydia cases in Nebraska has increased from 2010 to 2011 with 5,081 reported cases in 2010 and 6,416 cases reported in 2011. Whites, who make up 86% of Nebraska's population, had a case rate of 140 per 100,000 population. With 2,198 cases, African Americans,4.5% of the population, presented the second highest case rate of Chlamydia infections in 2011 with 1,635 cases and a rate of 197 per 100,000 population. This is followed by Hispanics, 9.2% of the population, with 476 cases reported bringing the case rate to 284 per 100,000 population.

In the highest percentages of Chlamydia infection occurs in females and males in the age range of 20-24 years at 42% followed closely by 25-34 years at 27% and 15-19 years at 25%. These age ranges of concern for Chlamydia infection in Nebraska is consistent with infection trends recognized nationally. Whites contribute 52% of the total cases reported, followed by African American Nebraskans with 34% and Hispanic populations with 8%. African American males have the highest percentage of total cases reported overall at 53% of the total reported cases for males, with White males at 47% in 2011. In comparison, it is White females with the highest percentage of total cases at 55% and African American females at 27%. In 2011, of the total cases reported for Chlamydia, females tallied 70% of the total cases reported and males contributed 30%.

Gonorrhea

Gonorrhea is a sexually transmitted disease (STD) caused by a bacterium that grows in moist warm areas of the reproductive tract and is a very common infectious disease. CDC estimates that, annually, more than 700,000 people in the United States get new gonorrhea infections and less than half of these infections are reported to CDC.

Gonorrhea infection and the populations it affects continue to be an area of focus for the Nebraska STD program. The Omaha Initiative, and convenient dual urine specimen collection kits, allows Nebraska's providers to engage in data driven non-traditional testing and screening events to over 33,700 consumers. Respectively 33,708 (9,523 male and 24,185 female) individuals were screened with Gen-Probes Aptima dual urine collection system resulting in a total of 1,334 cases reported in 2011. This is an increase from the 1,170 cases reported in 2010 and is a reflection of focused STD efforts.



In 2011, Whites, who make up 86% of Nebraska's population, had a case rate of 17.0 per 100,000 population with 266 cases. African Americans, 4.5% of the population, showed the highest case rate of Gonorrhea infection with 669 cases and a case rate of 807.1 per 100,000. The percentage of cases reported by age show that the percentages tend to be similar to what is found in our Chlamydia data. In 2011, 20-24 year olds have the highest percentage of frequency at 40% while 25-34 and 15-19 year olds present at 25%.

A noticeable difference between Gonorrhea and Chlamydia reporting is that the highest number of Gonorrhea cases reported has been found in African Americans with 50% of the total reported in 2011, while Whites represented 21%. African American males present the highest percentage overall at 59% of the total reported cases with White males at 17%. In comparison, it is also African American females with the higher percentage of total reported cases with 44% and White females at 22%. In 2011, of the total cases reported for Gonorrhea, females contributed to 60% of the total cases reported and males presented at 40%.

Syphilis

Syphilis is an STD which often goes undiagnosed and is referred to as "the great imitator" because signs and symptoms mimic other diseases and go away in the early stages only to show up late in the disease process when internal damage is taking place. Syphilis is easy to cure in the early stages. Generally, syphilis is transmitted through contact with a person in the primary or secondary stage of the disease through sores on the skin or mucous membrane lesions. In this manner, syphilis provides easy transmission of HIV infection due to the openings in the skin serving as a portal to the blood stream.

In 2011 there were 10 cases of Primary and Secondary Syphilis (P & S) reported to the STD program and 90% of those cases reported were male. Of the male cases reported, 9 total, 33.3% were White, 33.3% were African American, and 33.3% consider themselves other. There was one female (10%) identified under Primary and Secondary Syphilis (P & S) who was African American. In 2011 70% of the P & S cases reported were identified by sex and race however 30%, according to interview notes, considered themselves of multi-racial therefore they were categorized as Other (unknown).

Early Latent Syphilis diagnosis and dispositions in the year of 2011 were 100% identifiable by gender and 66% were identifiable by race, totaling 3 cases. One case was a White male, another case was an African American male, and only one or 33% of the total cases reported identified with Other (unknown).

TB

In 2011, Nebraska had a total of 23 cases of Tuberculosis, resulting in a rate of 1.3 cases per 100,000 people (Table 7.2). This is the lowest number of cases and attack rate in Nebraska in the last five years. The largest was 33 cases with a 1.9 attack rate in 2008. Nebraska ranked 39th nationally for the number of Tuberculosis cases in 2010 with 27 cases and continues to remain among the states with low Tuberculosis morbidity.

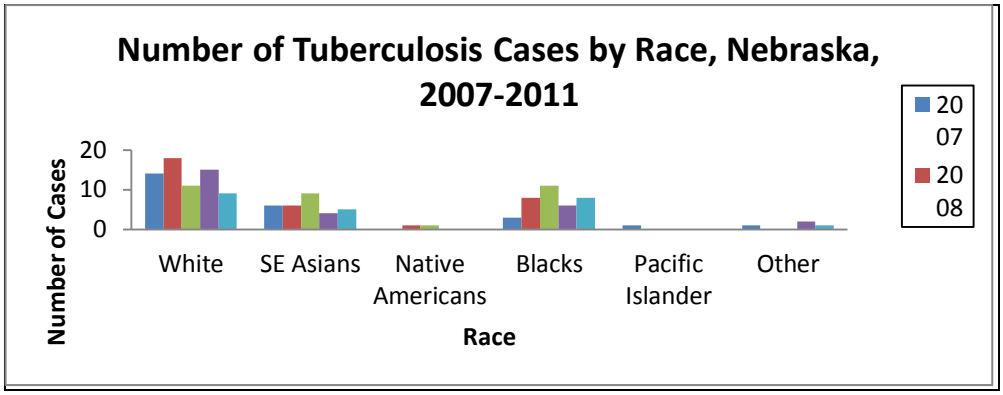
Reported Cases of TB and Attack Rates for U.S. and Nebraska, 2007-2011

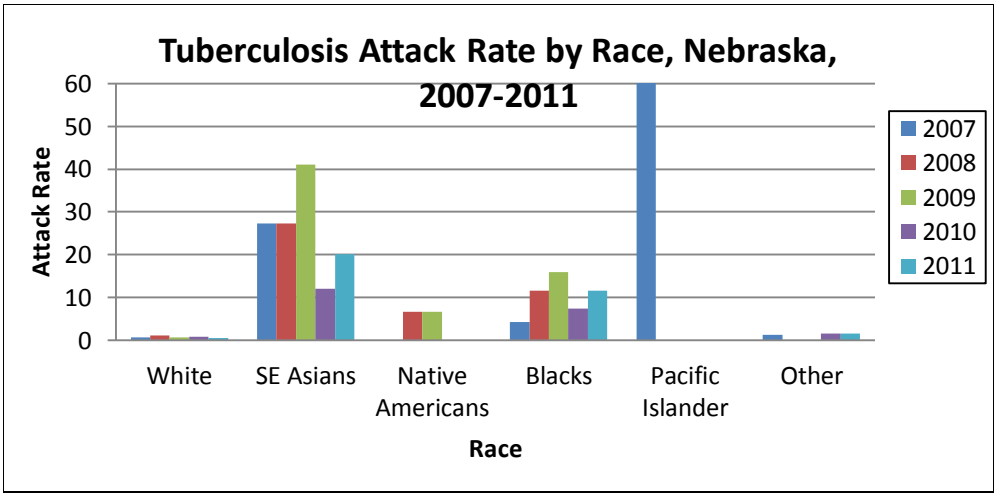
YEAR	U.S. CASES	U.S. ATTACK RATE PER 100,000 POP.	NE CASES	NE ATTACK RATE PER 100,000 POP.
2007	13,299	4.4	25	1.5
2008	12,898	4.2	33	1.9
2009	11.540	3.8	32	1.8
2010	11,181	3.6	27	1.5
2011	10,521	3.4	23	1.3

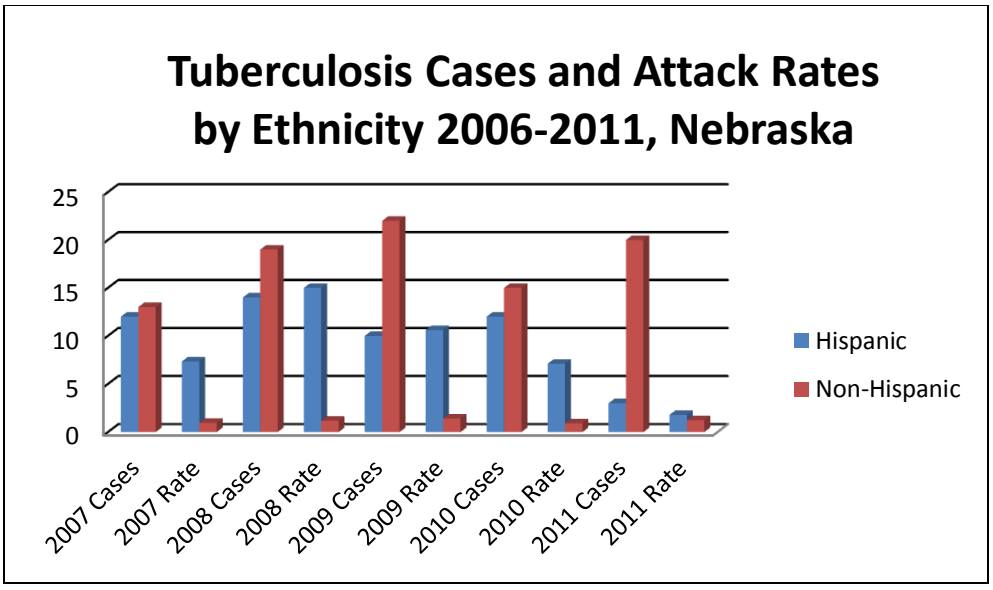
Attack Rates 2007-2008 Calculated Using Year 2000 U. S. Census Figures; 2009 rates used 2008 census data; 2010-2011 rates used 2010 U.S. Census Figures

Source: NE DHHS TB Control Program

Table shows the total number of cases and average annual attack rate of TB cases in Nebraska by race and ethnicity for 2007-2011.







Foreign born persons have a higher risk for exposure to or infection with M.Tuberculosis, especially those that come from areas that have a high TB prevalence, such as Asia, Africa, Latin America, Eastern Europe and Russia. Many persons from these groups now reside in Nebraska. During the years 2007-2011, the foreign-born accounted for 112 of 140 cases (80%) of tuberculosis cases reported. In 2007, they accounted for all 25 cases.

Douglas County (Omaha), Sarpy County (included in the Omaha metro area) and Lancaster County (Lincoln) in Nebraska are the state's three most populous counties and are located in the eastern third of Nebraska. Together, they reported 116 cases or 73% of the total cases reported during 2007-2011.

Nebraska Hepatitis C Trends

Based on the CDC estimates and 2010 Nebraska census data, one can estimate that approximately 18,263 Nebraskans may currently be infected with the Hepatitis C virus (HCV). It is also estimated that approximately 13,000 of those Nebraskans are unaware that they are infected, as HCV is a silent disease in that the liver does not show outward symptoms of damage until cirrhosis has developed. When a person is infected with HCV there is a 15-20% change that they will clear the virus on their own, however 80 - 85% of these infections will be chronic cases and therefore the individual will be capable of transmitting the disease to others. Also, HCV related illnesses account for approximately 17,000 deaths a year, with that number steadily rising to an estimated 35,000 in 2030. If HCV is undetected or untreatable in some patients the breakdown of health implications is serious.

Of every 100 persons infected with HCV, approximately

- 75–85 will go on to develop chronic infection; of those,
  - 60–70 will go on to develop chronic liver disease
  - 5–20 will go on to develop cirrhosis over a period of 20–30 years
  - 1–5 will die from the consequences of chronic infection (liver cancer or cirrhosis)

The newest Centers for Disease Control and Prevention (CDC) guidelines aim to remove the stigma of testing for HCV by making it a standard of care for anyone born between the years of 1945 and 1965. The estimates are that 75% of all infections are within this age group. The table below has been created to show how this would affect Nebraska's data. As a note, the categories of Nebraskan's Living with HIV/AIDS and the Inmate Population still include individuals 45-65 years old in their data as the rate of HCV infection in these two groups far exceeds the rate for those persons who should be tested once for HCV infection without prior ascertainment of HCV risk factors included in the 3.25% estimate by CDC. The category of "Other" was added as an estimate due to the lack of current information on those individuals that inject drugs and were admitted to a substance abuse treatment program.

Statistical Table estimating HVC disease in Nebraska, 2010.

Nebraska HCV Statistical Probability Table		National % HCV Positives	Nebraska # HCV Positives
CDC Guidelines for testing those born 1945 – 1965*			
Nebraska 2010 Census	1,826,341	1.00%	18,263
Nebraska's 45 - 65 years old (Minus A. & B.)	470,163	3.25%	15,280
		Remaining	2,983
HCV Known High Risk Populations			
A. 2010 Nebraska Inmate Population *(973 age 45-60)	5,469	35.00%	1,914
B. 2010 Nebraskans with HIV/AIDS *(767 age 45-64)	1,379	25.00%	345
C. Other - *Injecting Drug Use Treatment Admissions*			724
Statistical Positives for High Risk Populations		Total	2,983

2010 Nebraska HIV/AIDS Surveillance Report: http://dhhs.ne.gov/publichealth/Documents/2010SurvReport.pdf
2010 Nebraska Department of Correctional Services 36th Annual Report and Statistical Summary: http://www.corrections.state.ne.us/pdf/annualreports/2010%20NDCS%20Annual%20Report.pdf

Corrections

Inmates in jails and prisons across the United States are disproportionately affected by multiple health problems, including HIV, other STDs, TB, and viral hepatitis. Nationally each year, an estimated 1 in 7 persons living with HIV pass through a correctional facility. Most of them acquired HIV in the community, not while they were incarcerated. Compared with those who have not been incarcerated, incarcerated populations have more risk factors that are associated with acquiring and transmitting HIV, including injection drug and other drug use, commercial sex work, untreated mental illness, and lower socioeconomic status.

In Nebraska, State Statute requires that all inmates incarcerated within the State Corrections System are tested for HIV upon entry. Inmates testing positive are offered comprehensive health services. Upon release, HIV testing is voluntary for state inmates. They can also request HIV testing at any time during incarceration. Inmates within county corrections in Nebraska may be offered HIV testing as part of educational outreach activities conducted by local public health programs.

Mental Health

From July 22-27, 2012 an estimated 24,000 delegates, including people living with HIV/AIDS (PLHIV), researchers, implementers, journalists, policy makers, funders, advocates, and philanthropists from around the world gathered in Washington, DC for the 19th International AIDS Conference. This premier biennial conference seeks to shape the international response to the AIDS epidemic. In conjunction with the International AIDS Conference, CIHR, the HHS Office of Global Affairs, Health Canada, and the New York and New Jersey AIDS Education and Training Center co-hosted a satellite session on July 24, 2012, entitled, "Addressing Mental Disorders: The Missing Link to Effective HIV Prevention, Care, Treatment, and Support," along with other supporting organizations, including the National Institute of Mental Health, the United States Agency for International Development, the Joint United Nations Programme on HIV/AIDS, and the World Health Organization. Given that mental illness is both a risk factor for and a consequence of HIV/AIDS, the International AIDS Conference provided a unique opportunity to highlight the need to integrate mental health services into HIV/AIDS prevention, treatment, care, and support platforms. Accordingly, researchers, policy makers, advocates, and implementers working in the fields of HIV/AIDS and mental health shared promising models for the integration of mental health services into HIV/AIDS care programs, described challenges, and discussed the way forward for reducing the treatment gap for mental illnesses affecting PLHIV in high-, middle-, and low-income countries.

Former U.S. Ambassador Jimmy Kolker, currently the Principal Deputy Director of the Office of Global Affairs, opened the session by describing the gap between the mental health needs for PLHIV and available care. Francine Cournos, M.D., provided a research overview by highlighting the critical role treatment for mental illness/substance abuse can play in reducing morbidity and mortality, as well as improving the health outcomes for PLHIV with co-occurring mental illness/substance abuse. A diverse set of panelists working in the U.S., Canada, Vietnam, Uganda, and Zimbabwe discussed models, key ingredients, and challenges for integrating mental health treatment into HIV/AIDS programs.
The following themes emerged from the presentations and discussions:

- Task shifting/sharing (a process of assigning tasks to less specialized health workers) is a viable solution for addressing human resource deficiencies in mental health service delivery in low resource settings. Task shifting can be sustainable if health care providers are integrated into the workforce in tandem with other measures, such as continuous training, supervision, and opportunities for upward occupational mobility;

- Comprehensive and effective mental health services (prevention, treatment, care , and support) for PLHIV with co-occurring mental disorders/substance abuse includes biomedical, behavioral, and psycho-social intervention; and,
- Cultural competency in research, including participatory and decolonizing methodological approaches, can inform mental health services aimed at addressing the unique needs for members of ethnic minority groups, including aboriginal populations.

With reduced prevention funds coming into Nebraska, it is imperative that a comprehensive approach be utilized when planning and implementing prevention programs. Nebraska plans on strengthening the ties between HIV care and prevention and the mental health community as part of a strategic planning process scheduled for early 2013.

Substance Abuse

Sharing syringes and other equipment for drug injection is a well known route of HIV transmission, yet injection drug use contributes to the epidemic's spread far beyond the circle of those who inject. People who have sex with an injection drug user (IDU) also are at risk for infection through the sexual transmission of HIV. Children born to mothers who contracted HIV through sharing needles or having sex with an IDU may become infected as well.

Racial and ethnic minority populations in the United States are most heavily affected by IDU-associated AIDS. In 2000, IDU-associated AIDS accounted for 26% of all AIDS cases among African American and 31% among Hispanic adults and adolescents, compared with 19% of all cases among white adults/adolescents.

IDU-associated AIDS accounts for a larger proportion of cases among adolescent and adult women than among men. Since the epidemic began, 57% of all AIDS cases among women have been attributed to injection drug use or sex with partners who inject drugs, compared with 31% of cases among men.

In Nebraska, injection drug use is low, but still a risk factor identified in over 10% of known cases. Prevention must be comprehensive in its approach and include education on how to prevention sexual transmission of HIV. A strong focus on collaborating and partnering with Substance Abuse providers must be a priority to best utilize reduced prevention funding in the state.

Planning in Nebraska

In planning for the prevention and care services needs in Nebraska, numerous resources were tapped to gain a broad perspective and to best plan a course of action. The most intensive planning was done with the Nebraska HIV Care and Prevention Consortium (NHCPC). A two-day meeting was held in January, 2012. The latest statistical data was presented to the NHCPC membership, followed by small group brainstorming and discussion sessions. Members explored and identified Nebraska's prevention and care needs, resources, and gaps. There was a general consensus that stigma and an overall lack of emergency regarding HIV infection were priority prevention issues. A lack of appropriate care providers, especially in the rural areas, continues to be a challenge on the care services side. A complete summary from this two-day meeting can be found in the appendix.

The care services arena was thoroughly discussed by the Red Ribbon Community, an advisory group made up of Nebraskans living and/or affected by HIV. Again, needs, resources, and gaps were identified, along with a discussion on how to best reach out to the HIV positive community and those at risk for HIV infection and

transmission. The HIV positive perspective was also clearly reviewed via the 2012 Statewide Coordinated Statement of Need for Nebraska completed by the Ryan White Part B Program.

Sexual health professionals met for an all-day sexual health summit during 2012. Participants discussed the potential for collaborative research to better understand and more effectively address sexual health in Nebraska. The top five areas for research identified were: 1) Adult sexual health education/literacy, 2) Stigma, 3) Social Determinants of Sexual Health, 4) Policy, and 5) Changing Social Norms.

Additional planning activities planned include personal interviews with Federally Qualified Health Center staff and local health clinics. A phone survey is currently being conducted with Infectious Disease Doctors in Nebraska. The Nebraska HIV Resource Directory was updated (see copy in Appendix).

Planning will continue in early 2013, when a comprehensive strategic planning process is planned involving the NHCPC. Along with revisiting the structure and format of NHCPC regular meetings, the membership will be renewing and expanding their engagement efforts to identify additional resources that can be utilized. Of special interest will be expanding involvement in and with the mental health, substance abuse, and minority health communities. Part of this process will include refining priorities and clearly identifying shared values for prevention and care in Nebraska. While CDC has defined activities, the group will refine this process to create a prioritization model that includes both core services and defined populations for specific interventions.

Throughout all processes and work in place, the NHAS goals remain at the forefront as does the dedication to care and treatment of our populations. This clearly means this document and the Comprehensive Plan outlining specific implementation activities are fluid ones and will be revised to reflect changes, new thinking, and new collaborations and partnerships.

Resources and Resource Directory

Nebraska has a wide variety of HIV resources available across the state covering the span of information, testing, treatment, referral, support services and much in between. There remains room for improvement as identified in the gaps throughout the document. Emphasis will be placed on reducing these gaps. See 2012 Nebraska Resource Directory in Appendix.

Gaps

From the time that the first HIV Comprehensive Plan for Nebraska was developed in 2003, the HIV environment in Nebraska has shown little change. Target populations remain much the same, only expanding slightly to include slightly older populations who are either living with HIV or continue to exhibit high risk behaviors. Therefore, the identified needs of our target populations and the resources that are available in Nebraska have also remained much the same.

Ongoing care needs/gaps include lack of qualified care providers, transportation, housing, affordable healthcare, and access to medicines. Finding qualified prevention providers that want to target HIV risk populations has long been a challenge in Nebraska. Significant reductions in prevention funding from CDC has further challenged Nebraska in its prevention efforts.

Specific gaps and response plans are identified and explained in further detail throughout the following Narrative Plan of Action for Nebraska.

Narrative Plan of Action for Nebraska

The National HIV/AIDS Strategy was developed with three primary goals:

- Reducing the number of people who become infected with HIV
- Increasing access to care and optimizing health outcomes for people living with HIV
- Reducing HIV-related health disparities.

Nebraska will focus prevention and care efforts around these three goals.

Nebraska's status as a low incidence state for HIV disease is not surprising given the vast geography and total population of slightly less than two million people 1,842,641. Of this population, 39% live in the three extreme eastern counties of Douglas, Sarpy and Cass with Douglas County possessing 29% of the state's population. Omaha, the largest city in Nebraska (Douglas County), claims 23% or 419,545 citizens and is a part of the Omaha-Council Bluffs MSA. While the state is predominately comprised of Caucasians, Omaha's population is 13% African American compared to the state's overall 4.5 percentage.

Nebraskans, especially in rural and farming areas, are very conservative and it is no surprise the Omaha (Douglas County) area is where most of the men who have sex with men choose to live and/or socialize. This provides opportunities for social connections, medical services, greater acceptance, and access to a larger variety of services, education and employment. Approximately 50% of the people in Nebraska living with HIV disease identify as MSM. Of the 111 new cases of HIV/AIDS diagnosed in 2010, 72 or 65% came from Douglas County. MSMs represent 54% of all new cases in the Douglas County area with whites comprising 49% of new cases, African Americans 42% and Hispanic 7%. This differs from the numbers for the state as a whole where whites are at 55% of the total cases, African American at 32 % and Hispanic at 9%. Age breakdowns between county and state are similar in percentage concentrating between 15-44 years of age.

All of the above factors are considered carefully when planning prevention and care activities for the state. They all present both challenges and opportunities for planning, collaborating, and providing services.

HIV Counseling and Testing Referral Services

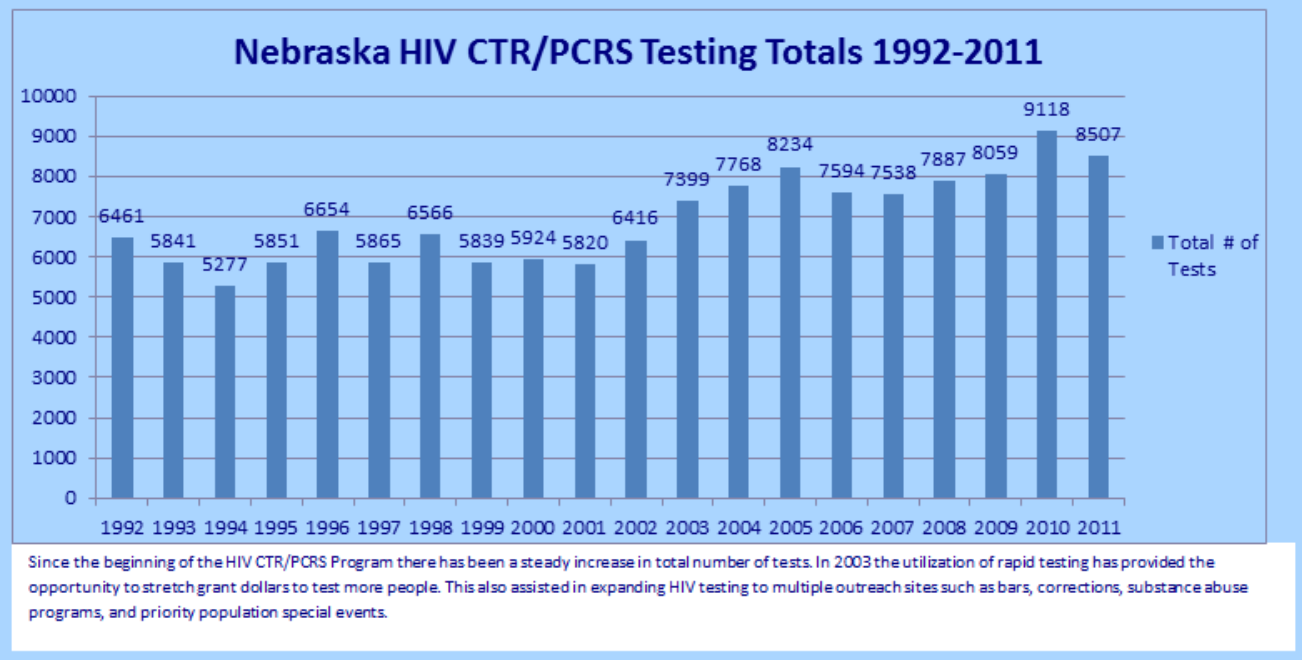
Action: Increase the number of at-risk individuals who know their status through increased, convenient and fast HIV testing and are referred to services.

> *Gaps addressed: Identifying and reaching hidden populations, high risk populations, and minority populations in areas where they are*

Knowing your HIV status is crucial to stopping the spread of HIV. We know that individuals are much less likely to engage in risky behaviors if they know they are positive. Individuals who are HIV positive and adhering to treatment overwhelmingly experience drastic reductions in their viral loads and are less likely to transmit the virus. Counseling and Testing Services are truly on the frontlines of prevention in our state.

Nebraska provides HIV Counseling and Testing services at public health sites throughout Nebraska. There are currently over 70 HIV counseling & testing sites in the state, including outreach testing provided by community-

based agencies. Testing sites use both rapid and conventional tests, although most agencies utilize rapid tests exclusively or predominantly. In Nebraska, rapid testing has allowed for the increase of testing because of a decrease in the cost per test. Advantages for test sites utilizing rapid testing means the ability to expand outreach to our high risk communities and clients receive real time results. Rapid testing opened up outreach activities to include discharge testing at state correctional facilities, testing at bars known to have MSM clientele, substance abuse centers, and various community special events serving specific populations.



Referral Services are provided at all Nebraska CTR/PCRS Test sites. During the Counseling Session if a client identifies needs outside of what the agency can provide, they can refer the client to known agencies in their geographic area. Agencies are required to have a list of referrals for their clients, and depending on the clients' needs, they may provide active or passive referrals to those agencies.

Since the beginning of the HIV CTR/PCRS Program there has been a steady increase in total number of tests. In 2003 the utilization of rapid testing has provided the opportunity to stretch grant dollars to test more people. This also assisted in expanding HIV testing to multiple outreach sites such as bars, corrections, substance abuse programs, and priority population special events.

Goals	Outcomes
NHAS: Reduce new infections; FOA: For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1% rate of newly identified HIV positive tests annually; Program: Increase HIV testing by 10% in disproportionately affected populations in Omaha, Nebraska. NHAS: Achieving a More Coordinated National Response to the HIV Epidemic & Increasing Access to Care and Improving Health Outcomes for People Living with HIV; FOA: At least 85% of persons who test positive for HIV receive their test results & at least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services; Program: Ensure that newly identified HIV positive individuals are receiving test results and receiving referrals to STD testing and partner services.	1. Areas identified of disproportionate new HIV infections in Omaha are utilized to determine new testing sites and support of established testing sites. 2. HIV testing is expanded to multiple non-health care sites in identified areas. 3. One key high risk nom-health care testing site will reach .8% positivity. 4. All counseling and testing sites will reach an 85% rate of clients testing positive receiving their results. 5. HIV CTR and STD*MIS data are analyzed showing 75% of new HIV positive individuals have been linked to partner services.

Referrals & Partner Services

Action: Ensure newly identified HIV positive individuals receive partner services and increase the number of partners of positive clients who are identified and appropriately tested.

Gaps to be addressed: Timeliness of connection of primary clients to DIS services for PN, linkage of partners to testing and referral.

Partner Services for HIV CTR Sites are administered through the Nebraska Sexually Transmitted Disease (STD) Program. All CTR sites are to report new positives to the Nebraska CTR/PCRS Program Manager who contacts the Nebraska HIV Surveillance Coordinator who then contacts the Sexually Transmitted Disease Program Manager who assigns Disease Intervention Specialists (DIS) to the newly diagnosed client. This process helps to provide checks and balances to ensure all three programs receive the necessary paperwork to complete data fields collected by the three programs and to ensure timely linkage of clients to partner services. Great strides in the prompt turnaround time for the investigation of new HIV positives is moving toward reaching the NHAS goals of Increasing Access to Care and Improving Health Outcomes for People Living with HIV, and Reducing HIV infections. Quicker DIS response results in newly identified positive individuals and their partners being linked to care and testing earlier. Improved disease management is essential to delaying the progression to AIDS.

Goals	Outcomes
NHAS: Increasing Access to Care and Improving Health Outcome for People Living with HIV; FOA: At least 85% of persons who test positive for HIV receiver their test results; Program: Partner with STD/DIS staff to ensure that all newly identified positives are initially contacted by a DIS within 48 hours of receiving their positive test result.	1. DIS will reengage agencies in the referrals of their positive clients to partner services. 2. Nebraska DHHS Program will work to identify and facilitate patient contact through extensive communication with agencies and clinics.
NHAS: Reducing New HIV Infections; FOA: At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services; Program: Ensure that all individuals receiving a HIV test at Nebraska HIV CTR sites are offered partner services.	1. Each agency will have scheduled site visit where they will receive additional information about the provision of partner services to their clients.
NHAS: Increasing Access to Care and Improving Health Outcome for People Living with HIV; FOA: At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment; Program: Ensure that newly identified positives in Nebraska receive partner services and are provided linkage to medical care.	1. DIS will contact at least 80% of new positives within 48 hours of client receiving their result.
NHAS: Achieving a More Coordinated National Response to the HIV Epidemic & Increasing Access to Care and Improving Health Outcome for People Living with HIV; FOA: At least 85% of persons who test positive for HIV receive their test results & at least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services; Program: Ensure that newly identified HIV positive individuals are receiving test results and receiving referrals to STD testing and partner services.	1. Nebraska CTR/PCRS Program will monitor PEMS and Evaluation Web reports for 2011 producing a baseline for future reports.

Prevention With Positives

Action: Increase timely linkages of HIV positive persons to care systems, support retention, and utilize data sources to support measurement of efforts.

Gaps to be addressed: Linkages to care systems for identified HIV positives, ongoing development of relationships with care providers to prevent supportive services, utilization of available data to measure and support effectiveness and/or presence of treatment.

The issues of linkage to care systems are critical to ensuring the best prevention with a positive available: effective ongoing treatment with appropriate antiretroviral treatment. As traditional prevention programs strengthen their direct activities such as counseling, testing and partner services, additional focus must be given to ensuring not only referrals to care but assurance of actual linkages achieved. This process serves as the foundational goals for Nebraska's Part C demonstration project which brings together all aspects under a one stop shopping umbrella. The project seeks to build the process from recruitment through an evidence based intervention, to testing processes with immediate services and referral. This is supported for positives by a

dedicated Linkage Coordinator who assures not only linkage to the medical system but also assistance in navigating it. Partnerships with major care providers ensure ongoing sharing of information to follow adherence. Prevention and changes in protection of self and partners are a part of the system. In addition, available data is collected through HIV Surveillance processes to track and measure viral loads as an indicator of effectiveness.

As an additional expectation for Nebraska CTR sites, completing the linkage to care is an expected part of the testing process. This is accomplished through the close collaboration with DIS, area HIV medical case managers through Nebraska AIDS Project, and partnership with our Ryan White Part B and C programs. Communication systems have been created and are being constantly improved to ensure linkages are made. A system of cross checks internally is in process to support this system. While the goal for this process is an 80% linkage, all HIV and related staff would be more than pleased to see this at 100%.

Further support and development of related care issues such as housing, mental health and substance abuse (as well as others) are also supported through relationships between providers, Ryan White systems and Housing Opportunities for Person With AIDS (HOPWA). The HOPWA program in Nebraska is part of the Infectious Disease Unit and well connected to all other programs.

A benefit that has been implemented and continues to build is the integrated STD testing that occurs at most CTR sites. This provides an opportunity, as a part of the counseling effort, to provide the increased risk created by STD's information in relation to HIV risks. Internally, Nebraska can relate prior STD infections to HIV infections which serve to better focus efforts in both programs.

As a measure for tracking ongoing improvement, the HIV Surveillance program is continuing to develop the capacity to measure community viral loads in targeted areas. This will be tried first as a part of the Part C project with focus on the Omaha area, but will be expanded to other areas in the future. The program is also working on attempting a preliminary measure of the HIV cascade which can then be utilized as a comparison from year to year to assist in determining where Nebraska can strengthen efforts. (Please refer to the Part C Demonstration Project later in this document.)

While really not on any measureable scale, one of Nebraska's best informal "interventions" with positives is its' Red Ribbon Community. This is a group of HIV positive persons who may or may not want to go public with their status but do want to be involved in activities from education to assisting other positives to advocacy. This group sends a representative our planning group as well as provides key input and "course corrections" for all of our programs. With fourteen current members, the group has key plans over the future to implement a variety of technology in communications, work with the issues of disclosure, develop a personal system "navigator" for the new HIV positive, and create educational and support materials specific to the needs of the new positive. Many of the members are very skilled in sharing their stories. They are supportive to our systems in many ways and our systems are able to support their efforts.

Goals	Outcomes

NHAS: Increase Access to Care and Improving Health Outcomes for People Living with HIV Infections; FOA: At least 85% of persons who test positive for HIV receive their test results; Program: Partner with STD/DIS staff to ensure that all newly identified positives are initially contacted by a DIS within 48 hours of receiving their positive test result. NHAS: Reducing New HIV Infections; FOA: At least 75% of persons who receive their HIV positive tests results are referred and linked to Partner Services; Program: Ensure that all individuals receiving a HIV test at Nebraska HIV Counseling, Testing, and Referral test sites are offered partner services. NHAS: Increase Access to Care and Improving Health Outcomes for People Living with HIV; FOA: At least 80% of persons who receive their HIV positive tests results are linked to medical care and attend their first appointment; Program: Ensure that newly identified positives in Nebraska receive partner services and are provided linkage to medical care. NHAS: Increase Access to Care and Improving Health Outcomes for People Living with HIV; FOA: Initiate use of Viral Load and CD4 data for estimating linkage and retention in care, community viral load, and quality of care; Program: Develop, implement and utilize VL and CD4 results to determine care linkage and status with a move toward measuring specific community viral load.	1. All CTR sites will have current and complete information regarding partner services, DIS, referrals and documentation. 2. DIS will reengage agencies in the referrals of their positive clients to partner services. 3. Nebraska DHHS programs will work to identify and facilitate patient contact through expensive communication with agencies and clinics. 4. Those who test positive will receive their test results. 5. DIS will contact at 80% of all new positives within 48 hours of the client receiving their result. 6. Viral loads and CD4 measures will be established as an ongoing measure of access, adherence and retention.

Social Marketing, Media and Mobilization

ACTION: Increase HIV awareness, knowledge of testing sites and engage partners in marketing and mobilization efforts.

Gaps and barriers to be addressed: social marketing, knowledge levels, public involvement, abstinence only education, complacency, burnout, stigma, conservatism, Nat'l standards for education

Public information activities alone do not represent a sufficient HIV prevention strategy. However, planning and implementing an effective and efficient public information program is essential to successful HIV prevention and care efforts in Nebraska. The Nebraska public information program crafts and delivers data-driven and consumer-based messages and strategies to very targeted audiences. The purpose of these efforts is to raise awareness, increase knowledge, refute myths and misconceptions, influence attitudes and social norms, reinforce knowledge, attitudes and behaviors, suggest and enable action, show the benefits of a behavior, increase support and/or demand for services, and help coalesce organizational relationships. The Nebraska public information program standards and guidelines are based on standards set by CDC.

Stop AIDS Nebraska (www.stopAIDSnebraska.info) is a comprehensive health communication program launched by the Nebraska DHHS designed to raise awareness of HIV/AIDS in the state. It incorporates many of the ACT Against AIDS (CDC) campaign materials that were designed to combat complacency about the epidemic and to reach specific populations at risk for HIV infection. Stop AIDS Nebraska supports and promotes local social marketing campaigns through free consulting and materials from the HIV Prevention and Care Library.

Materials created by the lead organization featured on www.aids.gov are used with modifications to make them more Nebraska friendly.

When	What	Where	How	Who
February	National Black HIV/Awareness Day	Douglas County Health Department Charles Drew Health Center North Omaha Community Care Council North Omaha Churches Local Stakeholders	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events Billboards	Black Community
	Youth AIDS Day	Douglas County Health Department Charles Drew Health Center North Omaha Community Care Council Ne Depart Ed OPS North Omaha Churches Local Stakeholders	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	18-24 Black People of Color At Risk People LBGT
March	National Church Week of Prayer for the Healing of AIDS	Douglas County Health Department Charles Drew Health Center North Omaha Community Care Council Mt Calvary Church St. Martin's Church Clare Memorial Church Salem Baptist Church Stakeholders	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	Black Community Church groups
	National Women and Girls HIV/AIDS Awareness Day	Girls Inc. Douglas County Charles Drew NOCCC UNO	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	Women of Color African American or black women
	National Native American HIV/AIDS Awareness Day	Omaha Tribe Ponca Tribe Winnebago Tribe Santee Sioux Macy, Fred LeRoy	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	Native Americans
April	STD Awareness Month	DHHS STD Unit and state and local health departments	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	General at Risk
May	National Asian HIV/AIDS Awareness Day	UNL State and Local Asian Service Organizations	Marketing Health Communication Educational Materials Support Counseling and Testing Events	Asian at Risk
June	National Caribbean American HIV/AIDS Awareness Days	State and Local Service Organizations	Marketing Health Communication Educational Materials Support Counseling and Testing Events	Caribbean Americans at risk
	National HIV Testing Day	State and Local Health Departments and CBOs	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events Billboards	General Nebraskans
July	Clinicians HIV Testing and Awareness Day	State Healthcare Organization	Marketing Health Communication Educational Materials	Healthcare Providers Primary Care

				Providers OB/GYNs, Certified Nurse Midwives Infectious Disease Specialists and Primary Care Providers who treat HIV
August	Nebraska State Fair	State Public Health Units	Marketing Health Communication Educational Materials	General
September	AIDS and Aging Day	State and local health departments and CBOs	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	People 50 and over
	National Gay Men's HIV/AIDS Awareness Day	State and local Health Departments and CBOs	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	Gay Men MSM African American or black gay and bisexual men
October	National Latino HIV/AIDS Awareness Day	SOCCC OneWorld NAP State and Local Health departments	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events	Latino Latina
December	World AIDS Day	State and local health departments Colleges and Universities	Marketing Health Communication Educational Materials Support events Support Counseling and Testing Events Billboards	The general public

The primary Public Information campaigns are: Act Against AIDS (CDC) and Let's Stop HIV Together – General Public; Testing Makes Us Stronger - African American or black gay and bisexual men; Take Charge, Take the Test - African American or black women; HIV Screening. Standard Care - Primary Care Providers; One Test. Two Lives. - OB/GYNs, Certified Nurse Midwives; Prevention Is Care - Infectious Disease Specialists and Primary Care Providers who treat HIV; Avoid the Stork Nebraska – The stork has taken on a second job, delivering STDs and HIV. This campaign is in the developmental stage and will be an extension of the University of Iowa Avoid the Stork campaign.

The Nebraska HIV Prevention Resource Library is patterned and linked to the National Prevention Information Network. It and Stop AIDS Nebraska will continue to provide a one-stop place for the public and professionals to get educational materials. Using CDC guidelines, the NHCPC needs assessment and priority list, the web site will be revamped to include pages for MSM, LGBT, Positive People, Friends/Family and Oral Care. The speaker's page, library page, home page and calendar page will be updated. Web sites and pages are:

www.stopAIDSnebraska.info	http://dhhs.ne.gov/publichealth/Pages/dpc_hiv.aspx
Home	http://dhhs.ne.gov/publichealth/pages/dpc_Ryan_White.aspx
Calendar	http://dhhs.ne.gov/publichealth/Pages/dpc_hivmaterials.aspx

Speakers	http://dhhs.ne.gov/publichealth/Pages/dpc_NHCPC.aspx
Positive People	http://dhhs.ne.gov/publichealth/Pages/dpc_NHCPC.aspx
Gay MSM	http://dhhs.ne.gov/publichealth/pages/dpc_HOPWA.aspx
LGBT	http://dhhs.ne.gov/publichealth/pages/dpc_Hep_C.aspx
Family and Friends	http://dhhs.ne.gov/publichealth/Pages/std_index.aspx
In the News	http://dhhs.ne.gov/publichealth/pages/cod_Tuberculosis_tbindex.aspx

DHHS receives communications daily from people across Nebraska. Based on requests, the library staff links them to HIV prevention activities, organizations, and people who can help them. Pamphlets, posters, booklets, and hotline information (Ne211) are sent on request and materials are created upon request. The turnaround time is generally 24-48 hours.

The Public Information Coordinator supports and participates in national, state and local media campaigns for getting the HIV/AIDS prevention message to targeted populations and committees. Active participation in numerous committees, panels and organizations across the state keep the public information coordinator updated. Oral Manifestations of STDs and Infection Control Updates for Healthcare Providers are programs on deck in 2012-2013.

Channels used to reach target populations are Traditional Mass Media, Online and Social Media and Community and Provider Events. Examples of Channels are: TV PSAs, Radio PSA and On-Air Reads, Print Advertising, Outdoor Advertising, Web Banners, Chick0through Banners, Buttons and Badges, Online Videos, Listserv, Facebook, Twitter.

The NHCPC Public Information Committee Members play an active part in planning and implementation of campaigns and materials. The work diligently to encourage community mobilization, to create environments that support HIV/AIDS prevention by actively involving community members in efforts to raise awareness, build support for and involvement in HIV prevention efforts.

Goals	Outcomes
NHAS: Reduce new HIV Infections; FOA: Reduce new HIV infections; Program: Increase awareness and knowledge of HIV, HIV testing sites through target media and marketing.	1. Increase number of tests associated with media mobilization campaigns. 2. Increase the percentage of people living with HIV who know their status. 3. Increase the number of people living in Nebraska who know their status. 4. Increase the number of government workers, community based organizations and people living in Nebraska who request assistance, materials and support from the Public Education Coordinator.

Condom Distribution Plan

ACTION: Increase prevention efforts by increasing access to and distribution of condoms through targeted sites and creative awareness and access campaigns.

Gaps to be addressed: availability of and access to the frontline prevention of use of condoms.

The proper use of condoms has long been considered a front line prevention tool. While Nebraska has included condom distribution in the programs for many years, there were considerable restrictions on how they were to be distributed when using CDC dollars to supply them. The only restriction at this juncture is the very concentrated focus on HIV positives and high risk negatives. Condom distribution, as a new major focus for HIV prevention does present some challenges in Nebraska. Our efforts will increase through a variety of outlets through the coming years. While the program cannot directly distribute condoms, the work will be more effectively accomplished through key providers located in supported CTR sites, CBO's and their locally located satellite sites, outreach sites located in venues where target populations are, and key events such as PRIDE.

A key ongoing part of this effort is the continuous building of awareness. Messages and education continues to be focus for the public education staff person who also builds creative campaigns around prevention topics and methods. Refer to the previous section.

To ensure condoms are being picked up and utilized by our target populations, the program will do a six month pilot project to determine condom brand and size preferences. Much discussion has been centered around the potential ineffectiveness CD if preferences are not honored. To this end, a variety of brands and sizes will be available to specific groups to determine what is selected the most by users. If it is found to be financially feasible and fiscally responsible, then changes will be permanently initiated. Preference will not apply to items such as vibrating condoms, etc. but rather to key brand and sizes of basic condoms.

New for 2012 and continuing through 2013 is the development, implementation, and evaluation of a mixed media coordinated campaign developed by a local design group. This is being supported through funding to the Nebraska AIDS Project at the primary focus initially is in the Omaha area. The campaign is branded, utilizes all forms of social media, including a dedicated website, and a variety of print, poster and ads. The primary message is that of safety presented in unique ways centering on the use of condoms. It is targeted to the younger cohort of MSMs who are at risk in the target area. The campaign will also develop and utilize materials based on race and ethnicity in the sense of ads representing a variety and not implying a singling out of a specific race or ethnicity. The campaign will also be available in Spanish. This effort is set to launch via "hit it hard" method in December.

Note: Specific evaluation and goals for the new campaign are in the completion phases now.

Goals	Outcomes
NHAS: Reduce new HIV Infections;; FOA: Conduct condom distribution to target HIV positive persons and persons at highest risk of acquiring HIV Infection; Program: Reach MSMs in the Omaha/Douglas County area, especially those of color, with targeted condom distribution activities.	1. Distribution of condoms will increase by 20%. 2. CD locations will increase by 20%. 3. Hits on the Web sites will increase by 25%. 4. Orders through the social marketing site will increase by 10%.

Health Education and Risk Reduction (HE/RR)

ACTION: Create alternatives to traditional HE/RR implementation due to significant decreases in funding and changes in FOA emphasis.

Gaps to be addressed: lack of funding, prevention in rural areas, lack of training

Historically, the greatest provider of funding for HE/RR activities in Nebraska has been the CDC. With the implementation of NHAS, and the resulting shift of funds, Nebraska is now in a position where little to no funding is available for prevention other than CTR and public education campaigns.

In the years immediately preceding these funding shifts, Nebraska funded four SISTA Programs (Omaha X 2, Lincoln, and Grand Island) that targeted women at high risk of HIV infection. The Voices/Voces Program was offered in Lexington and targeted a largely migrant Hispanic population, especially women. The Popular Opinion Leader (POL) Program was implemented in Omaha and targeted MSM. Of all these programs, only the POL Program will continue past 2012 due to the funding cuts from CDC.

The Nebraska Department of Health and Human Services HIV Prevention Program does have a successful mini-grant program that allows for the funding of small, community-based, innovative projects. This program will continue through 2013 and beyond as funding allows.

Goals	Outcomes
NHAS: Reduce new HIV Infections; FOA: Decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV; Program: decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV.	1. The HIV prevention program will implement HE/RR programs in Nebraska as defined by NHAS and the FOA and as funding allows.

Demonstration Project – *New for 2012*

ACTION: Demonstrate effectiveness of integrated prevention to testing to care linkage in a highly impacted area of a low incidence state.

> *Gaps to be addressed: availability of Evidence Based Interventions, focused testing, partner services and linkages/retention in care services.*

The information presented herein makes it clear that Counseling &Testing efforts should include focused efforts in the Omaha area. There are multiple testing sites located in the Omaha/Douglas County area including the local health department, a federally qualified health center, family planning sites and the state's only AIDS service organization, Nebraska AIDS Project (NAP). It is NAP who has the closest link to the MSM population. As the only community-based AIDS Service Organization in Nebraska for 26 years, NAP provides comprehensive support services the entire state, as well as 11 counties in southwestern Iowa and 2 counties in eastern Wyoming. Annually, NAP tests over 2,000 individuals. With their connection to and support of the MSM population, NAP offers an excellent resource for reaching those who do not know their status.

While a number of effective program components exist within the Omaha area, it was determined that an integrated, comprehensive one stop shop targeted to MSM, especially of color, would be an effective approach for this community in reducing transmission through awareness of status, education, immediate partner services, intensive support for linkage and retention in care and validation through data support and evaluation. Nebraska AIDS Project offered the ability and infrastructure to efficiently implement the components of this demonstration project. The project utilizes a university based evaluator who is also doing extensive work with gay populations.

This multi-prong integrated approach was built on an existing and established behavioral intervention; testing in creative and data directed geographic areas supported by immediate access to a Disease Intervention Specialist for partner support; immediate initiation to care service linkage through intensive case management and ongoing follow-up to maintain connection to care; utilization of data elements including geocoding to better target efforts and measure results; connection with University of Nebraska MSM focused evaluation experts to build and guide effective outcome data collection, measures, and analysis; and, utilizing creative elements in existing infrastructures to ensure efficiencies, impact and replicability.

The project focuses on men who have sex with men in the Omaha-Douglas County, specifically ranging in age from 19 to 44, with a heavy emphasis on increasing the reach to African American men who have traditionally been a hidden population in this state. New collaborations are being developed and existing ones strengthened.

By utilizing and building on the existing Popular Opinion Leader (POL) evidence based intervention, a sense of familiarity is achieved. POL continues to grow and has achieved credibility in the area through their training, outreach and effectiveness to date. It is through data analysis of the 482 people reached in 2010-2011, NAP learned 88% of their participants did not know their HIV status (3% reported they were positive, 9% negative). Although there is anecdotal data that knowledge improved, tracking mechanisms and formal documentation mechanisms were not in place. This will be a change to the program as will an emphasis on, and increased access to, non-traditional testing venues to improve knowledge of HIV status among this group. Part of the formal evaluation effort is to determine how to most effectively measure knowledge change of, or impact of the outreach "conversations" and follow-up of testing efforts. Specific recruitment of African American POLs is targeted as well. This community level intervention is one of the entry points to the integrated system.

HIV Counseling, Testing, Referral and Partner Services comprise the second tier of the project. A minimum increase of 10% in testing numbers with at least 90% partner services and 100% referral are the targets. The regular onsite NAP testing site has been maintained. This site also provides urine based Gonorrhea and Chlamydia testing as well as limited Syphilis testing. Special testing sessions are held at events such as Gay Pride and other GLBT sponsored events. Regular testing has been set up at a local gay bar. Others are in negotiation. An outreach worker provides testing at homeless shelters. In addition to improving the testing in data driven venues, a part time, fully trained Disease Intervention Specialist was added to the agency. This is in response to requests from gay men testing at NAP. They feel the staff is familiar with their concerns, understand how to effectively work with their gay partners and/or contacts and this can all be accomplished without having to go somewhere else or disclose information to a person from another agency. With ability to efficiently elicit and contact partners through this integrated system, it is anticipated the number of partners contacted, tested, referred and linked to services will improve significantly.

For those individuals testing positive, the third component in this system is case management and linkage to medical care. While NAP has very capable case managers in place currently, the allocation of part of a case manager to function as a Linkage Coordinator for all new positives will be an effective addition. This case manager has a very limited case load in order provide intensive services to new positives designed to link them immediately to medical care, ensure attendance at medical visits, ensure connection to ADAP and HOPWA as needed, provide needed guidance and counseling and to provide risk reduction services. As the client is stabilized, they are transferred to a permanent case manager. This effort is also a part of the formal evaluation process to measure effectiveness, timeliness and adherence.

The final piece of this project is strengthening and integrating data components into this effort. An HIV experienced data analyst from the HIV program is utilized. HIV Surveillance was awarded supplemental funds to develop geocoding and mapping services. These processes were being utilized, in conjunction with e-Hars and STD data to identify areas of highest risk. This will assist in efforts to focus testing in specific geographic areas. In addition, a measure of community viral load will be attempted by target areas for both purposes of testing and to hopefully begin to measure improvements in care linkage and prevention efforts.

Along with the state HIV Prevention program and Nebraska AIDS Project, collaborators and partners extend to the University of Nebraska Medical Center, HIV Care Specialty clinic, Ryan White Parts B and C, ADAP, HOPWA, other area medical providers, HIV Surveillance, STD programs, faith based organizations and other community partners. Stronger linkages with African American based agencies and organizations are a goal for the project.

The intended outcome of this project to expand the reach in Omaha and Douglas county to all MSMs to reduce risk, know their status, connect with and stay in care if positive, maintain negative status if negative, reduce stigma, and learn as well as practice good sexual health. As the project unfolds and implementation continues, ongoing dissemination of the findings will occur through the Nebraska HIV Care and Prevention Consortium as well as through state website project updates. (Please see Part C Evaluation Plan included in Appendix)

Goals	Outcomes
NHAS: Reduce new HIV Infections;; FOA: Focus prevention efforts in communities where HIV is most heavily concentrated to achieve the greatest impact in decreasing risks of acquiring HIV; Program: Reach MSMs in the Omaha/Douglas county area, especially those of color, with targeted peer prevention education and HIV testing to reduce transmission risks and increase overall awareness of status.. NHAS: Reduce new HIV Infections;; FOA: Increase HIV testing; Program: Reach MSMs and their partners in the Omaha/Douglas County area with convenient HIV and urine based STD testing supported by a trained Disease Intervention Specialist to offer immediate partner services. NHAS: Increasing access to care, improving health outcomes for people living with HIV; FOA: Increase access to care and improve health outcomes for people living with HIV by linking them to continuous and coordinated quality medical care and much needed prevention and social services. Program: All new agency positives will be referred to a NAP Linkage Coordinator who focuses only on these individuals to ensure fast and efficient linkages to medical, social and housing services as well as risk reduction education and counseling.	1. Two training sessions are held the first year with four the second year and 3-5 POLs trained each session with up to 40 conversations in target population year one and 80 in year two. 2. All trained POLs and 25% year one and 35% of those reached with conversations are tested for HIV (or already aware of their status). 3. Two Social events year one and three events year two are held with participants reporting knowledge gained, testing completed or safer sex materials acquired with plans to use. 4. Testing is implemented and maintained in five new sites achieving a .05% positivity. 5. An agency DIS is in place and provides partner services to at least 75% of all new positives identified by the agency. 6. Three new representative C&T counselors are trained and working in targeted sites. 7. At least 85% of all new positives receive their results. 8. At least 60% of persons who receive their confirmatory HIV test results are linked to medical care and attend their first appointment. 9. Timelines of linkage to care improves by 50% over baseline. 10. At least 50% of new HIV positives accept linkage to care services. 11. Clients receiving linkage to care services experience improved outcomes as measured by adherence, retention, and reduced viral loads.

Policy Development

ACTION: Improve internal and external processes to ensure confidentiality, reduce barriers to/for HIV positive persons and enhance access to all services.

> *Gaps to be addressed: Integrated confidentiality and security policies internally, legal/regulatory barriers impacted HIV positive persons, access to affordable, accessible services.*

The program is charged to support efforts to align structures, policies and regulations in the jurisdiction with optimal HIV prevention, care and treatment and to create an enabling environment for HIV prevention efforts. These efforts must comply with the new (and stricter) lobbying restrictions under federal law.

The effort to align regulations and laws in Nebraska must be a collaborative one among all those who work with and care about HIV prevention. As a state agency, the program is very limited in participation in the process of legislative activity therefore much of that effort will need to emanate from the community. Regulatory barriers are an area that can be studied with recommendations made through channels for action.

The HIV program is following an internal approach first to ensure there are no internal policies or barriers as well as to ensure the ongoing confidentiality and security protections. To this end, the first internal policies to be addressed are the implementation of an integrated Security and Confidentiality policies and procedures across the infectious disease programs unit. While each program has had policies in place, in the past, some have served as a barrier to ensure transitions from testing to care, to retention in care and re-engagement. This comprehensive

plan addresses paper, electronic, cubical security, computer security, access, etc. This effort is in process and should be completed by the end of 2012.

The second major area and potential barrier to be addressed will be data sharing across the unit with very limited major partners as appropriate, legal, and approved. This will require significant study to determine all issues and ensure highest security and confidentiality are preserved throughout.

The third step for this program is to work with partners to identify specific laws and/or regulations that could be a barrier to HIV prevention and care services. These would be prioritized and appropriate venues for action determined.

Goals	Outcomes
NHAS: Increasing Access to Care and Improving Health Outcome for People Living with HIV; FOA: focus HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact in reducing the risks of acquiring HIV; Program: Revise internal and external policies and earmark regulations or laws needing revision to ensure an enabling environment for HIV prevention and treatment.	1. Unify security and confidentiality across the entire unit. 2. Improve security of workspaces when patient data is being worked with by staff. 3. Formalize data sharing policies across the entire unit. 4. Begin identifying specific laws or regulations that could be a barrier to HIV prevention.

Ryan White Program

HIV Care Services

ACTION: Increase the access to, linkage to and retention in HIV care services.

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) is the largest single source, next to the Medicaid and Medicare programs, of federal funding for HIV/AIDS care for low-income, un- and underinsured individuals. HRSA administers all Ryan White Parts for HIV care and treatment and is the federal agency to which the Nebraska Ryan White Program reports.

Nebraska receives funding from Part B of the Ryan White CARE Act. Funds are utilized to provide economic assistance for rent, utilities, transportation, health insurance, food, and nutritional supplements to individuals infected with HIV disease. Part C healthcare and healthcare related services are offered through the University of Nebraska Medical Center (UNMC) in Omaha which provides services to the eastern two-thirds of the State and Western Community Health Resources (WCHR), located in Chadron, which provides services in the panhandle region. Together these services allow individuals who do not qualify for Medicaid, Medicare, or private insurance to access needed services.

Ryan White Part B

ACTION: Provide coordinated wrap around and drug assistance services to HIV positive clients.

Gaps to be addressed: Prevention and care in rural areas, specialty care, transportation

The Ryan White Part B Program is administered by the Nebraska Department of Health and Human Services and funded through the federal Ryan White HIV/AIDS Reauthorization Act of 2009 legislation. The Health Resources and Services Administration (HRSA) is the federal entity responsible for the administration of Ryan

White funding. Ryan White Part B funding is allocated to all fifty states and U.S. territories through formula funding.

The DHHS Ryan White Part B Program is located within the Nebraska Department of Health and Human Services, Division of Public Health, Infectious Disease Prevention and Care Unit. The administrative offices are located in Lincoln, Nebraska. The Program Administrator is responsible for overall program oversight of the HIV Prevention, Ryan White, HOPWA, Viral Hepatitis, STD, TB and HIV Surveillance programs. The Program Manager is responsible for direct oversight and day to day operations of the Ryan White Program. The Client Services Coordinator is responsible for the oversight of Part B statewide case management and direct emergency assistance/emergency financial assistance program components.

The purpose of the Ryan White Part B Program is to provide funding and services for the following program areas to individuals who reside in the state, meet financial eligibility requirements, and have no other access to said services.

- AIDS Drug Assistance Program (ADAP) – Providing therapeutic medications for the treatment of HIV infection;
- Direct Emergency Assistance/Emergency Financial Assistance – Providing support services such as housing, utilities, transportation, food, and insurance premium payment assistance; and
- Comprehensive Case Management Services – Providing access to Ryan White funded services and assistance in accessing other eligible services for qualified clients.

The Ryan White Part B program allocates funding to Outpatient and ambulatory health services, ADAP, Early Intervention Services, Oral health care, Home health services, Health Insurance premiums for low income individuals, mental health and substance abuse services, and medical case management, to include treatment adherence services.

These services are provided to individuals who reside in the state, meet financial eligibility requirements, and have no other access to the above services.

Nebraska's Ryan White Part B Program activities support the following goals of the Healthy People 2020 initiative, which overlap with prevention services efforts and other services:

Reduce the number of cases of HIV diagnoses among adolescents and adults.

Through the provision of therapeutics for the treatment of HIV disease, Nebraska's AIDS Drug Assistance Program (ADAP) enables many clients to decrease their detectable levels of HIV in the blood stream and bodily fluids. Fewer copies of the virus mean decreasing opportunities for the virus to infect others.

Reduce the number of perinatally acquired HIV and AIDS cases.

The recommendations by the CDC that all pregnant women in Nebraska be offered testing for HIV, and if found to be HIV+, be afforded treatment to prevent vertical transmission from mother to child. This is an on-going initiative collaboratively with the AETC and the HIV Prevention and Care programs. Progress is made daily, and legislation to remove barriers to general informed consent has been passed by the legislature.

Increase the proportion of new HIV infections diagnosed before progression to AIDS

Increase the proportion of persons surviving more than 3 years after diagnosis in 2002.

With rapid HIV testing technology, diagnosis of HIV can be done without invasive procedures. Social marketing campaigns hold the key to getting more individuals into testing for early diagnosis. Also, partnering with medical providers for HIV testing will facilitate early diagnosis of HIV disease.

Through the provision of medications through Nebraska's ADAP for the treatment of HIV disease and HIV related opportunistic infections, supportive services to increase stability of living situations and case management to assist in identifying and working to decrease risk behaviors, the interval of time between initial diagnosis of HIV infection and an AIDS diagnosis is extended. Further, an increase in life expectancy and productivity is expected if the interval of time between initial diagnosis of HIV infection and an AIDS diagnosis is increased.

Reduce deaths from HIV Infection.

Through the provision of therapeutics through ADAP, access to case management services, access to direct emergency funding, and collaboration with Part C entities in the state death rates from HIV will continue to decline.

Increase the proportion of persons living with HIV who know their serostatus.

Through collaboration with Nebraska's CTR PCRS program individuals who test positive are referred to the appropriate services to include Part B and Part C services in the state. In addition, a major Ryan White collaborator, Nebraska AIDS Project, also has testing sites with trained counselors who can assist persons with HIV positive results in identifying further contacts for testing and referral. Utilizing this social network system assists in increasing those at risk for testing and potential identification of more positives. By state statute, all laboratories performing laboratory services for the State of Nebraska are required to report HIV+ tests results to the Nebraska HIV Surveillance Program, thereby providing additional assurance that these persons will be directed to services as soon as possible after an HIV diagnosis.

Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

The network is in place between Part B collaborators, Nebraska AIDS Project and the University of Nebraska Medical Center (UNMC), as well as close collaboration with the two Part C programs to ensure identification and referral of HIV positive persons happens in a timely and efficient manner. UNMC as the major service provider closely follows the PHS guidelines as does the Part C program in the Panhandle. UNMC specialists are available to consult with other physicians across the state to ensure PHS guidelines are known and followed.

Coordinating with the Viral Hepatitis, STD, TB and HOPWA Programs at the State, the Ryan White Part B Program will target activities to ensure that seventy-five percent of newly enrolled HOPWA/Ryan White Part B clients will receive education and referrals for screening and testing for Hepatitis, STD and TB and information regarding the HAV/HBV vaccination. It will be the goal to have fifty percent of the HOPWA/Ryan White Part B clients vaccinated for HAV/HBV and eighty percent of the newly enrolled HOPWA/Ryan White Part B clients diagnosed with a co-morbidity will accept treatment made available to them.

Case Management

Gaps to be addressed: patient resources to care and support services

The PROVIDE® Case Management software system allows for in depth data collection, documentation of client activities, and case planning to enable case managers to effectively document client information. The system also

allows for the Client Services Coordinator (and HOPWA Coordinator) to ensure information is clear and accurate in the review of client information in processing requests for assistance. Finally, the Provide system provides for in depth data collection for required reporting both at the agency and state level, as well as for quality assurance and evaluation activities.

Case management is currently offered to clients statewide through a subgrant with Nebraska AIDS Project (NAP). NAP provides case management services in five offices located in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff. NAP also receives Part C (Western Nebraska Part C Program funds) funding for case management, bilingual services, HIV outreach/education, and counseling and testing. With funding from both Part B and Part C in the state, NAP is able to coordinate services offered by each program for clients in need.

In FY 2011 (April 1, 2011-March 31, 2012), the Ryan White Part B Program provided case management and direct emergency assistance (housing, utilities, transportation, health insurance, and food assistance) to 529 unduplicated clients.

AIDS Drug Assistance Program (ADAP)

Gaps to be addressed: Expanded access to health insurance for clients

The AIDS Drug Assistance Program (ADAP) provides medications to low-income individuals in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam who are infected with HIV disease. Qualified individuals have limited or no coverage under Medicaid, Medicare, or private insurance which may provide access to medications for the treatment of HIV disease.

As of June 25th, 2012, Nebraska's ADAP formulary includes approximately 124 medications including medications currently approved by the FDA for the treatment of HIV disease, opportunistic infections and for mental health issues.

In addition to Federal funding, ADAP receives an additional State funding for HIV medications. The UNMC acts as the ADAP provider for Nebraska. Qualified individuals statewide receive medications either through walk-in pharmacy services at the hospital or through a mail order system.

The Nebraska AIDS Drug Assistance Program had implemented a waiting list for enrollment into the program. Unfortunately the need for drug assistance has increased, costs of medication increased and funding remained the same or decreased over the past year. All of these things have impacted the ADAP budget, leading to the waiting list. The waiting list, instituted in October, 2011, reached a high of 244 by June 2012. An infusion of federal Emergency Relief funding in June of 2012 allowed the list to be closed by August 2012.

When seeking drugs (ADAP) outside of the University of Nebraska Medical Center (UNMC), the patient may want to seek assistance from their specific provider. ADAP is operated through a subgrant with the University of Nebraska Medical Center. Dr. Susan Swindells M.B.B.S. is the ADAP Director. Physicians statewide are able to access ADAP through a mail order system with the UNMC Pharmacy. Clients who live locally can access the UNMC outpatient pharmacy directly. Clients living in other areas of the state receive medications via mail order through the pharmacy.

University of Nebraska Medical Center (UNMC) Ryan White Part C Program

ACTION: Ensure linkage of HIV positive persons to medical care services.

Gaps to be addressed: Access to services in metro/rural areas.

The UNMC Ryan White Part C Program, directed by Dr. Susan Swindells, M.B.B.S., an Infectious Disease Specialist; provides early intervention services (EIS) to clients residing in the eastern three-fourths of Nebraska as well as portions of Southwest Iowa.

The program's mission is to provide comprehensive services to those at risk for or infected with HIV disease. EIS services are provided primarily through the UNMC HIV clinic and associated services at UNMC in Omaha: primary HIV Health Care (outpatient visits and lab), ophthalmology, mental health care, oral health care, nutritional consultation, pap smear and annual TB skin testing. The program also provides services through contracted physicians, dentists, and mental health/substance abuse providers located throughout the eastern two-thirds of the state.

UNMC's Part C program provides rural clients access to Early Intervention Services (EIS) through the availability of an outreach clinic held every eight weeks in Grand Island, Nebraska. The program also expands access to healthcare by offering evening hours at the HIV clinic in Omaha, thereby providing services to those who are unable to attend clinics held during the day.

UNMC Ryan White Part C Program Goals
Goal 1: Continue to provide HIV counseling, testing, referral, and partner counseling services in central and northeast Nebraska, with access to bilingual services.
Goal 2: Continue to provide medical evaluation, clinical care, and patient education.
Goal 3: Continue to ensure that UNMC Part C clients are receiving coordinated, high quality HIV care.

Chadron Community Hospital and Health Services (CCH) Ryan White Part C Program

ACTION: Ensure linkage to medical care services

Gaps to be addressed: Access to services for HIV positive persons in rural areas.

CCH's Ryan White Part C program service area is comprised of the eleven western most counties in Nebraska, known as the Nebraska Panhandle. While it is one of the smallest Ryan White Part C programs in the country, it has one of the largest and most rural service areas. The medical director, an infectious disease specialist, travels 200 miles from Denver to conduct bi-monthly HIV clinics. Prior to CCH receiving Ryan White Part C funding in 2000, there was minimal primary care and no comprehensive care provided to HIV positive individuals residing in the service area.

Program Goals
Goal 1: Increase access to care services
Goal 2: Optimize health outcomes
Goal 3: Identify and move into care newly diagnosed HIV positive individuals

University of Nebraska Medical Center (UNMC) Part D

The University of Nebraska Medical Center (UNMC) Part D provides family-centered primary medical care to women, infants, children, and youth (WICY) living with HIV/AIDS when payments for provided services are unavailable from other sources. The service area is the state of the Nebraska excluding the Panhandle region, and including 11 counties in Southwestern Iowa. Part D provides coordinated, comprehensive, culturally and linguistically competent services including HIV counseling and testing, medical evaluation, clinical care and patient education, oral health care, adherence education and/or prevention counseling, mental health/substance abuse services, nutritional counseling, referrals for specialty care, medical case management and outreach support.

Objectives/Goals
1. Access To Care: HIV counseling, testing, and linkage to care.
2. Comprehensive, Coordinated Primary HIV Medical Care including prenatal services, women's health care, specialty referrals and adherence services.
3. Other Medical and Support Services including mental health and substance abuse screening and outpatient treatment, oral health care, nutrition screening and therapy, medical case management and outreach support.
4. Clinical Quality Management Program to ensure Part D clients are receiving coordinated, high quality HIV care.
5. Consumer Involvement in planning, implementation and evaluation of the Part D program

Statewide Coordinated Statement of Need (SCSN)

Actions and Gaps covered in narrative.

The most recent Statewide Coordinated Statement of Need was completed and submitted in 2012. Due to Nebraska being a low incidence state with an epidemic that does not change significantly from year to year, the results of the SCSN did not vary significantly from past SCSNs. As in the past, the SCSN identified many recurrent issues that are not easily addressed. Two of the most consistent issues raised by providers and patients were the lack of ambulatory health services such as laboratory work in the central region of the state and increased need for dental care.

FY2012 planned allocations continue to address these issues by placing additional funds into each line item. There may be an issue with finding a willing provider of dental services in several regions of Nebraska due to a general lack of providers, as well as the limited return on investment for practices reimbursed at the Medicaid rate. Part B funds have been distributed through a contract with the UNMC HIV clinic to assist with the provision of dental services.

The planning process consists of nursing, medical and social case managers, providers from rural and urban settings, AETC staff, Part C staff and administrators and consumers. RW and HIV Prevention staff also participated in the process. The following are the significant issues identified in the 2012 SCSN:

Geographic distance to providers/Lack of Transportation

Nebraska encompasses 77,358 square miles with the majority of the population residing in the eastern third of the state. The remaining two-thirds of the state is largely rural in nature with limited healthcare and supportive services for individuals living with HIV/AIDS. As a result, individuals may have to travel long distances to access care, supportive services, and case management. FY 2012 allocations provide transportation assistance in the form of gas vouchers in rural areas and bus tickets/cab fare for individuals in urban areas to access essential services.

Affordable Healthcare

Affordable healthcare is an overriding issue for everyone. Limited funding in the past two years and increasing levels of individuals accessing Ryan White funded services in the state has placed increasing pressure on the current system of care to provide adequate services to clients. The Part B program does not generally provide direct healthcare or healthcare related services (with the exception of ADAP), but coordinates with the two Part C funded entities in the state to provide accesses to Part C services. Over the last several years, Part B has funded very limited services for physician visits and lab services in geographical areas not covered under Part C.

Lack of healthcare providers, mental health, and substance abuse services

The two Part C entities in the state are responsible for providing healthcare, mental health, and substance abuse services in their respective regions. The Part C HIV clinic in Eastern Nebraska conducts HIV clinics every two months in the central part of the state for clients who do not have access to an HIV specialist. A Part C clinic is held bi-monthly in Gearing at Community Action Partnership of Western Nebraska (CAPWN) to provide those same services to the western areas of the state. The Ryan White Part B Program is establishing increasing relationships with new providers in Central Nebraska to provide additional measures to ensure that early intervention services will continue to be available to clients impacted by the lack of service provision in the Southeastern and Central regions of the state.

Lack of affordable housing

Lack of affordable housing is another recurrent issue, especially in rural parts of Nebraska. With Nebraska receiving HOPWA funding, qualified clients are able to access housing that has become more affordable with HOPWA's Tenant Based Rental Assistance program providing long term financial assistance and stability for clients. While this is significant, there is a shortfall in HOPWA funds for the foreseeable future, so Part B funds have been and will continue to be utilized to support limited housing needs of consumers.

Access to Medications

FY 2012 ADAP earmark funding will be utilized to fund ADAP along with $900,000 in state funds. Additions to ADAP from the Part B base will be utilized to shore up any unforeseen or unanticipated ADAP costs as well as to support Medicare Part D premium co-pays and premiums. With the impending move to count ADAP as TrOOP, Nebraska is trying to anticipate the impact of the budget, both good and bad, related to medication access for clients.

Lack of Knowledge Regarding Availability of Ryan White Services

Co-location of the Ryan White and HOPWA programs enables both to work to increase awareness for clients of the other program. Publication of electronic and web-based information will be utilized to address this need, as well as the aforementioned RW Part B, C and HOPWA Services Table, which delineates available services and eligibility requirements. When the HOPWA Program holds client training sessions, both programs and services are addressed. HOWPA can also provide referral to Ryan White services for transportation and food needs identified. The Program is also developing new brochures.

STD Intervention and Prevention Activities

ACTION: Incorporate those at an increased risk of HIV transmission through integration with sexually transmitted disease detection.

Gaps to be Addresses: Access to STD testing statewide with appropriate treatment and education regarding risk and prevention.

The DHHS STD Control Program is funded by a federal grant from the Centers for Disease Control and Prevention (CDC). This funding covers staffing costs, contractual services with Douglas County Health Department (DCHD) and Lincoln Lancaster County Health Department (LLCHD), grant required travel, and minimal supplies. This program partners with two STD clinics, 66 NIPP/semi-STD testing sites throughout the state, community health agency, and federally qualified health agencies to provide screening for chlamydia, gonorrhea, syphilis, and in some instances HIV.

These clinics include family planning clinics, community health centers, Indian Health Service clinics, correctional facilities, county and district health departments, hospitals, women's health centers, university health clinics, primary care clinics, youth center clinics, and a large number of private health care providers. STD services are coordinated with the Title X Program, HIV/AIDS Prevention, Hepatitis B and C, HIV/AIDS Surveillance, the Tuberculosis Program and the NDHHS Office of Minority Health. The key populations that STD efforts in Nebraska focus on are:

1. Persons who are incarcerated
2. Persons with substance abuse issues
3. Uninsured, disparate, and marginalized populations
4. Persons engaging in activity with high transmission rates

The STD Control Program encourages and support any outreach efforts that focus on providing health education, screening, and treatment to hard-to-reach minority communities. The targeted minority groups in Nebraska are diverse and span statewide with minority organizations such as:

1. One World, Charles Drew Health Center, People City Mission Clinic, Nebraska AIDS Project
2. Winnebago and Macy Tribes
3. Women's Health Center, UNK Student Health, Wayne State College
4. Douglas County Corrections, Work Ethic Camp, York Corrections

One of the programs' goals is to ensure that screening is provided for chlamydia, gonorrhea and syphilis in all of the counties that have large numbers of incarcerated populations and that local service providers target this population for screening and testing. STD Control Program works closely with three state correctional facilities and two juvenile correctional facilities to provide screening/testing, treatment, and partner services.

Statewide, the DHHS STD Control Program provides the latest guidelines regarding STD's, their diagnosis and treatment to health care providers. Information, educational materials and posters are distributed to screening sites and community agencies upon request. Many materials are available in different formats and languages. In recent years, there has been a noted increase in the need for interpreters and educational materials for refugees and immigrant populations. These language barriers make it very difficult to maintain confidentiality when a third party is required for interpretation. The transitory nature of refugee populations makes it difficult to locate patients for follow-up when investigating an STD.

The STD program continues to develop intervention and prevention activities across Nebraska as needs are identified. In FY 2011-2012, the following new activities were implemented:

1. *STD Control Program/STD Clinic Chalk Talks*: A quarterly teleconference was implemented for the STD Control Program Manager and STD clinic supervisors. This activity is initiated by the STD Control

Program Manager to communicate any program updates or changes and to discuss DIS case loads and concerns.

2. *STD Control Program Case Protocol*: This protocol was developed in conjunction with a HIV surveillance to assist DIS in the management of chlamydia, gonorrhea, syphilis, HIV, and co-infection cases. Currently state and Douglas County DIS use this case protocol.
3. *Semi-STD Sites*: 66 testing sites across Nebraska implemented enhanced testing for women who would not be covered by the Infertility Prevention Project guidelines for testing and their male partners.
4. *Increased Testing and Targeted Screening*: When funding is available, the STD Control Program was able to increase testing and screening opportunities for women and men at various non-traditional events in high morbidity areas of Omaha, NE. Treatment provided for positives and partners. Sites include libraries, concerts, school physicals, haunted houses, and churches.
5. *Implemented Syphilis Classification Algorithm*: This algorithm is a collaborative tool that is utilized by state and local DIS to appropriately diagnose and disposition syphilis cases collectively. Final review of all syphilis cases will be done by STD Control Program Manager prior to CDC submission.

Nebraska has one STD coalition in Douglas County called the North Omaha Coalition and consists of members from the Omaha/Douglas County area: Charles Drew Health Center, Douglas County Health Department, Center for Human Diversity, Alegent Health, 100 Black Men and 100 Black Women, and STD Control Program staff. The goal of this coalition is to decrease the rate of gonorrhea and chlamydia in North Omaha.

The STD goals for 2013 center around decreasing time between identification of new positives and first interaction with DIS; ensuring timely linkage to potential partners with resultant testing; increasing linkages with correctional programs, and tightening policies and procedures as well as data and security.

Nebraska Infertility Prevention Program (NIPP)

The Region VII Infertility Prevention Project (IPP) is or Prevention of STD-Related Infertility is a program that is funded through the Centers for Disease Control and Prevention (CDC) and is administered collaboratively by the CDC and the Office of Population Affairs (OPA). The overall goal of the Region VII IPP is to lead a collaborative effort with STD Directors, Family Planning, and laboratory program managers to prevent and reduce STD related infertility within its regional area. That includes Nebraska, Kansas, Missouri, and Iowa.

Nebraska Infertility Prevention Program (NIPP)) focuses on the prevention and early treatment of chlamydial and gonococcal infection through collaborative relationships with Federally Qualified Agencies, Family Planning Clinics, Healthcare Centers, two STD clinics, substance abuse, Nebraska AIDS Project, county and state Corrections (including youth), and private providers throughout Nebraska. The program currently supports several different testing accounts from traditional clinics to non-traditional, such as testing in libraries. Express clinics have increased the number of men being tested and correctional site testing can help to ensure treatment before release.

NIPP provides medication, as recommended by 2010 CDC Treatment Guidelines, to almost all memorandums of agreement clinic sites. Sites must fill out a new Confidential Treatment Case Report form (TCR) that lists the initial positive patient and are encouraged to provide their sex partners. Positive clients can ask that their partners be presumptively treated or can come into the clinic and be tested free of charge.

Nebraska is currently moving to the Electronic Lab Information Reporting Technology (ELIRT) system which is a secure electronic system for ordering test supplies, submitting results, receiving results within 48 hours and the

ability to transform data into an electronic spreadsheet at the touch of a button. All clinics will be trained and will use this environmentally friendly, paperless system by the close of 2013.

NIPP Program emphasis in the next few years will be on continuing the screenings for chlamydia/gonorrhea targeting young, sexually active women and men located in high morbidity areas. This will include improving the appropriate and timely treatment for persons with chlamydia and/or gonorrhea and their partners. There will be a focus on incorporating data analysis into prevention strategies to better reach targeted populations. Improved communication between NIPP clinic sites should increase staff competence through information and webinar sharing, email updates, and CEU opportunities.

Changes Anticipated in the STD Program

The STD Program plans to continue a number of current efforts as well as include new ones. There is always room for improvement and the Nebraska STD Control Program is continually uncovering new strategies and providing support to local agencies that have a real understanding of their community. This approach assists STD providers in providing services that meet their communities where they need to be met, establish trust and rapport, and find infection.

Nebraska has seen an influx of immigrant and migrant populations to the state over the past few years. In the past this has created problems with communication when it comes to testing sites, health care providers and follow-up disease investigation. Currently in Nebraska DIS can locate interpreters that are well versed in confidentiality, cultural norms, and various languages. Over the next few years the STD Control Program would like to share and secure this opportunity for all of our providers. This would ensure that all clients of the STD program will be afforded the opportunity to relay their medical questions and concerns clearly, consistently, and without judgment.

Electronic Lab Reporting (ELR), the demand for better data collection and the increase of medical records has caused the STD Control Program to question the modality reporting, billing, and submission of required data to grant sources. The DHHS Office of Epidemiology and National Electronic Data Surveillance System (NEDSS) currently serves as the leading source of positive STD reporting for the State of Nebraska however its results have to be manually entered in CDC's data collection program. In addition the CDC's data collection system is limited in variable submission and has an unforeseen future. The Nebraska STD Control Program is currently investigating several data collection solutions and hopes to have one in place by spring of 2013.

Over the next five years, the goal of the Nebraska STD Control Program is to decrease the number of STD's in Nebraska through increased community awareness and involvement, by continued communication with private, public, local health departments, and correctional providers, increase DIS presents state wide, and create and maintain long-term collaborations with DHHS programs with similar diverse underserved populations.

For further information on STD's in Nebraska go to the DHHS STD Program website at:
http://dhhs.ne.gov/publichealth/Pages/std_index.aspx

TB Intervention and Prevention Activities

ACTION: Increase the percentage of TB patients who are tested for HIV.

Gaps to be addressed: HIV status of TB patients, linkage to treatment, precautions of both treatments due to drug interaction.

The face of Tuberculosis in the State of Nebraska is changing. The TB Control Program has seen an unprecedented increase in the number of foreign born persons with tuberculosis in the last twelve years. While Nebraska still remains low in overall TB morbidity, the challenges presented by this new phenomenon are great. The language and cultural barriers of this population require a tremendous amount of public health resources to ensure a successful TB treatment outcome. Nationally, there continues to be a great need for research in tuberculosis to develop new diagnostic tools and new drugs to fight the disease. Nebraska has not yet seen the increase in multi-drug and extensively drug-resistant disease, but these are showing up more frequently around the world and we realize that the global burden of TB is not far away from Nebraska's borders. For the past twelve years, federal funding to the State has decreased with the recent years rescissions. Currently, this program runs on a total budget of approximately $350,000.

Objective and Performance Target

Known TB Cases with Positive or Negative HIV Test Results	
Year	**Rates**
2012	68%

The Nebraska TB Program has chosen this objective for an extensive evaluation. The rationale for selecting this evaluation focus area is because our current National Tuberculosis Indicators Project (NTIP) report shows that Nebraska is well below the national average for collecting HIV status information on newly diagnosed active TB patients. For the years 2007-2009, Nebraska's average was 58% of patients diagnosed with active TB who had either a positive or negative result. The National average during this time was 79%. HIV status information is very important because it could impact the patient's treatment and their response to treatment. On a yearly basis, the TB Program and the HIV Surveillance program match registries to be sure that all co-infected cases are documented.
The Report of Verified Case of Tuberculosis (RVCT) form, which is used for collecting information on all active TB cases, includes a section on HIV status. The HIV status may be listed as: negative, positive, indeterminate, refused, not offered, test done-results unknown, and unknown. This information is based upon medical documentation or patient history.

5 Year Percentage of TB Cases with Reported HIV Status, Nebraska

Year	**2007**	**2008**	**2009**	**2010**	**2011**
% of TB cases with HIV status reported	**68%**	**67%**	**62%**	**81%**	**82%**

For further information on TB in Nebraska go to the Nebraska DHHS TB Program website at:
http://dhhs.ne.gov/publichealth/Pages/cod_tuberculosis_tbindex.aspx

Hepatitis Intervention and Prevention Activities

The CDC has estimated that one out of every four people infected with HIV is also infected with the Hepatitis C virus (HCV). The presence of HCV and HIV in a client can impact the treatment and management of both HCV

and HIV infections. This co-infection has also been significantly associated with higher titers of the Hepatitis C virus, a more rapid progression to advanced liver disease and is a leading cause of death in persons living with HIV/AIDS.

As there is no vaccine to prevent Hepatitis C viral infection, prevention of the spread of this virus is critical. Viral Hepatitis, Sexually Transmitted Diseases and HIV all have similar risk factors and modes of transmission. Therefore, CDC has recommended that prevention strategies and efforts for these viruses be combined.

ACTION: Ensure Public Health Efforts address Hepatitis – HIV Co-Infection**.**

Gaps to be addressed: Lack of local involvement in prevention

Currently there is not a developed Viral Hepatitis webpage, task force or local public health department involvement in planning prevention efforts for HCV-HIV Co-Infection. Ground work will be done to create this foundation over the next year.

ACTION: Decrease number of new cases of HCV infection in persons living with HIV/AIDS.

Gaps to be addressed: Integrated prevention education materials.

Currently the information provided is separated into the categories of Viral Hepatitis, TB, HIV and STDs. The focus on Co-Infections with HIV will require updated materials to be found, utilized, created and printed for these exhibits. Information linking the programs together and how the routes of infection and plans of treatment must be coordinated for co-infections. New Continuing Education Nursing presentations will have to be created in coordination of all programs listed to give a comprehensive, interrelated program that addresses HIV Co-Infections with Viral Hepatitis, TB and / or STDs.

ACTION: Increase the proportion of persons who are aware of their hepatitis C virus infection and increase knowledge and reduce HCV related complications.

Gaps to be addressed: Consumer knowledge of co-infection and related health issues. Linkage to care resources.

Currently HIV surveillance data is not analyzed with a focus on co-infections with Viral Hepatitis, TB and / or STDs. Collaboration with the HIV/AIDS Surveillance Program will be vital to analyze the target populations affected by co-infection with HIV. Viral Hepatitis does not have extensive and structured programs for linkage to care. However, those co-infected with HIV and Viral Hepatitis would be able to utilize the HIV based linkage to care. Individuals co-infected with HIV and Viral Hepatitis would have access to programs that would greatly increase the client's ability to receive appropriate care, medication and services which address their needs when co-infected with HIV.

Program Collaboration and Service Integration (PCSI)

ACTION: Ensure HIV efforts to integrate with TB, STD, Hepatitis, Ryan White, HOPWA, and HIV Surveillance to extend the reach of all programs.

Gaps to be addressed: client knowledge of co-infections

The Centers for Disease Control and Prevention defines Program Collaboration and Service Integration (PCSI) as a mechanism of organizing and blending inter-related health issues and services in order to maximize the public health impact. With the decrease in prevention funds coming into Nebraska, PCSI takes on an even greater value in our work.

Nebraska has an advantage at the state level in that the HIV Prevention, Ryan White, HOPWA, STD, Surveillance, TB, and Viral Hepatitis programs are all in the same division at NHHS. Collaboration and integration of services is the common standard for all the programs. Efforts continue to ensure that there is a continuity of services for clients accessing CTR sites. Since CTR sites provide Chlamydia/gonorrhea screening, this supports clients and partners receiving services to benefit from education regarding sexual health and decision making.

While testing for Hepatitis B and Hepatitis C is encouraged, there is no funding to support this effort, though for several years the Viral Hepatitis Program was able to offer testing and vaccination through limited sites. Efforts will continue to identify additional resources to continue these activities. The Tuberculosis Program has established HIV testing for all active disease patients as their standard. Nebraska has been working on development and implementation as an integrated group for a number of years. An integrated plan supported by an integrated evaluation plan in now in place. Please see the Nebraska PCSI Evaluation Plan in Appendix?

Engagement

ACTION: Strengthen current collaborations and develop new linkages to providers of HIV-related services as a part of the overall planning process.

> *Gaps to be addressed: Physicians, smaller CBO providers, hospitals, substance abuse treatment providers.*

Guidance from CDC instructs states to ensure that populations with the greatest burden of the epidemic and those at greatest risk for HIV transmission and acquisition are identified. To this end, states must streamline the HIV planning process to support expanded partnerships and a coordinated local response to the epidemic to best achieve the goals of NHAS. This includes an enhanced focus on improving communication, coordination, and implementation of services across the continuum of HIV prevention, care, and treatment services.

To a large degree, this will be best accomplished through the work of the Nebraska HIV Care and Prevention Consortium (NHCPC). With the refocusing brought about with the release of the NHAS, being a low-incidence state has meant less resources are now coming into the state. Being a low-incidence state can also be an advantage for those working in the prevention and care arena. It is common for individuals and agencies that provide these services to wear many hats, providing both prevention and care services to their clients. This allows for the establishment of greater trust levels for clients. With less agencies providing services, communication and coordination is more manageable and collaboration is a necessity.

The NHCPC has done an excellent job of engaging community members, key stakeholders and service providers who can best inform and support the HIV prevention priorities of NHAS and Nebraska. A comprehensive strategic planning process is planned for 2013 to examine how the NHCPC can best assure that engagement continues to be a priority in Nebraska. This will include looking at ways to "expand our circle," identifying additional partners in our efforts to gather information and provide comprehensive services to Nebraskans across

the state. Of special interest will be expanding involvement in and with the mental health, substance abuse, and minority health communities.

Nebraska HIV Care and Prevention Consortium

ACTION: Conduct a thorough strategic planning process that includes a review of the membership, structure, and meeting format of the NHCPC.

Gaps to Address: increased networking and collaboration opportunities, training

Since 1993, the Centers for Disease Control and Prevention (CDC) has directed states and localities to conduct a community planning process to address the challenges of the epidemic and maximize the effectiveness of HIV prevention and care activities. In response, the Nebraska Department of Health and Human Services (NHHS) initiated a comprehensive community-based participatory planning process in February 1994. Today, this statewide planning body is known as the Nebraska HIV Care and Prevention Consortium (NHCPC). The NHCPC includes representatives from all geographical regions of the state. It is a comprehensive planning body with representation from HIV prevention and care providers and consumers, STD, TB, and HEP programs, public health, behavioral health, substance abuse, corrections, education and members of populations at risk for HIV infection in Nebraska. Several members of the NHCPC are people living with HIV/AIDS.

The NHCPC acts in an advisory capacity to the NHHS HIV Prevention and Ryan White Programs. Through this advisory relationship, the HIV Prevention and Ryan White Programs respond to the care and prevention issues affecting those at risk for HIV infection, as well as those who are currently living with HIV/AIDS. The NHCPC advises the NHHS on the development and on-going monitoring of the Nebraska Jurisdictional Plan.

The CDC released a revised Prevention Planning Guidance in the summer 2012. The new guidance details how community planning has evolved into HIV planning, which aims to contribute to HIV prevention through the development of both targeted and broad-based collaborations among stakeholders. HIV planning will entail broadening the group of partners and stakeholders engaged in prevention planning, improving the scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition. The NHCPC plans on engaging in an in-depth strategic planning process beginning in January 2013. The overall structure of the group membership, by-laws, meeting schedules, etc. will be thoroughly examined to determine how Nebraska can best meet the goals for NHAS and for the state. The strategic planning process will highlight current engagement practices, helping to identify additional community partners and community resources that the group can draw upon.

Goals	Outcomes
NHAS: Reduce New HIV Infections; FOA: Focus HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact in reducing the risks of acquiring HIV; Program: Nebraska will support broad-based, state-wide community participation in HIV planning.	1. A Jurisdictional Plan will guide prevention activities throughout Nebraska.

It's been 30 years since we first began hearing about this strange, new disease. There are people new to the fight and they bring strength, energy and passion with them. Many have been on the frontlines since the beginning and they remind us of the terrible fear, pain and stigma that so many of our friends have faced. It will take the combined efforts of us all to beat

this disease. Never has the need to collaborate, multi-task, and just plain watch out for each other been so vital. All voices must be at the table and they must all be heard. *Together*, Nebraskans can continue to move forward, always forward!

Better integration of all prevention and treatment services is critically needed.

HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention--first, to help the uninfected stay that way; second, to help infected people stay healthy; and third, to help infected individuals initiate and sustain behaviors that will keep themselves safe and prevent transmission to others. CDC, Division of HIV/AIDS Prevention, 2007.

Appendix

NHCPC Membership
CTR Test site map
Resource Directory

Nebraska HIV Care and Prevention Consortium Membership

Membership – July, 2012

BERNICE AFUH
Lincoln-Lancaster County Health Department
3140 "N" St
Lincoln NE 68510
WK: 402 441-6216
HM: 402 435-5846
CELL: 402 450-4321
Representing: Direct Provider for STDs
Committee: Assessment & Evaluation

JANE ATHEY
Nebraska DHHS –
Longterm Care & Medicaid Div
301 Centennial Mall South NSOB - 5th Fl
Lincoln NE 68509
WK: 402 471-9119
HM:
CELL:
Representing: Medicaid Issues
Committee: Membership

ANDREW BRACKETT
Nebraska AIDS Project - Kearney
11 W Railroad PO Box 2378
Kearney NE 68847
WK: 308 338-0527
HM: 308 293-0176
CELL:
Representing: MSM - Rural (+ or -)
Committee: Interventions

FRANCES CARODINE
3325 Fontenelle Blvd, Apt 226
Omaha NE 68104
WK:
HM: 402 763-9240
CELL:
Representing: Minority HIV Impacted
Committee: Membership

LINDA CHASE
5615 N 61st Av
Omaha NE 68104
WK:
HM: 402 686-4241
CELL:
Representing: Native American / American Indian
Committee: Public Information

DANIEL COBOS
UNMC - Ryan White Part C Program
804 S 52nd St PO Box 988106 N.M.C.
Omaha NE 68198-8106
WK: 402 559-5750
HM: 402 630-0424
CELL: 402 888-1010 (bpr)
Representing: Part C Coordinator
Committee: Care Services

JACQUELINE COOK
Charles Drew Health Center
2915 Grant St
Omaha NE 68111
WK: 402 457-1208
HM: 402 451-4509
CELL: 402 510-9979
Representing: Eastern Region
Committee: Public Information

CHRISTOPHER FISHER
UNMC College of Public Health
986075 NMC
Omaha NE 68198-6075
WK: 402 559-3835
HM:
CELL: 402 517-7711
Representing: Behavioral Health
Committee: Assessment & Evaluation

SUSAN GOODMAN
Central Health Center
217 E Stolley Prk Rd, Ste E PO Box 2539
Grand Island NE 68801
WK: 308 384-7625 x202
HM: 308 383-1659
CELL: 308 383-1659
Representing: Central Region
Committee: Assessment & Evaluation

LEE HEERTEN
UNL Health Center
1500 'U' St
Lincoln NE 68588
WK: 402 472-7498
HM: 402 419-9777
CELL:
Representing: MSM - Urban (+ or -)
Committee: Interventions

STEVE JACKSON
Nebr DHHS-Infectious Disease Prev and Care
301 Centennial Mall South, 3rd Fl PO Box 95026
Lincoln NE 68509
WK: 402 471-2504
HM:
CELL: 402 610-0938
Representing: State Part B Coordinator
Committee: Care Services

JEREMY JOHNSON
UNMC - AIDS Drug Assistance Program
804 S 52nd St 988106 NMC
Omaha NE 68198-8106
WK: 402 559-4673
HM:
CELL: 402 290-5163
Representing: AIDS Drug Assistance Program
Committee: Co-Infection

CHRIS JUNKER
Nebraska Dept of Education
301 Centennial Mall South, 6th Fl PO Box 94987
Lincoln NE 68509
WK: 402 471-4490
HM:
CELL:
Representing: Division of Adolescent and School Health – Nebr Dept of Education
Committee: Co-Infection

PEDRO MANCILLA
1701 S 9th St
Omaha NE 68108
WK:
HM: 402 502-9063
CELL: 402 972-0052
Representing: Injecting Drug User
Committee: Membership

WENDY MCCARTY
University of Nebraska - Kearney
B 159 College of Education
Kearney NE 68849
WK: 308 865-8074
HM: 308 381-2743
CELL: 308 390-2529
Representing: Behavioral Health
Committee: Interventions

PAT O'HANLON
One World Community Health Center
4920 S 30th St, Rm 103
Omaha NE 68107
WK: 402 502-8988
HM: 402 558-7581
CELL:
Representing: Minority CBO
Committee: Co-Infection

ANNE O'KEEFE
Douglas County Health Department
1111 S 41st St
Omaha NE 68105
WK: 402 444-7213
HM: 402 933-0092
CELL: 402 403-7247
Representing: Epidemiologist
Committee: Assessment & Evaluation

JAMES POPPERT
8708 Fowler Av
Omaha NE 68134
WK: 402 502-1555
HM: 402 319-8039
CELL:
Representing: Mental Health / Substance Abuse
Committee: Assessment & Evaluation

GALEN SEARS
PO Box 2511
Grand Island NE 68802-2511
WK:
HM: 308 389-3418
CELL:
Representing: Red Ribbon Community
Committee: Membership

JEFF TRACY
Comm Action Partnership-Western Nebr Hlth Ctr
3350 10th St
Gering NE 69341
WK: 308 633-3728
HM: 308 635-6668
CELL:
Representing: Part C Coordinator
Committee: Care Services

TIM PERLINGER
1014 N Broadwell Av
Grand Island NE 68803
WK:
HM: 308 390-4980
CELL:
Representing: Person Living with HIV or AIDS
Committee: Membership

LISA SCHULZE
Planned Parenthood of the Heartland
PO Box 80773
Lincoln NE 68501
WK: 402 441-3320
HM: 402 770-0610
CELL:
Representing: Southeast Region
Committee: Public Information

JANET SOULE
Com Action Partnership-
Western Nebr Hlth Ctr
3350 10th St
Gering NE 69341
WK: 308 633-3264
HM: 308 436-5803
CELL: 308 631-6842
Representing: Western Region
Committee: Care Services

ANGI TRAN
Northeast NE Family Health Services
230 E 22nd Street, Suite 4
Fremont NE 68025
WK: 402 727-5336 Ext 211
HM: 402 758-0633
CELL: 402 719-7790
Representing: Northern Region
Committee: Public Information

NANCY VOSSLER
Dept of Correctional Services - Medical Dept
PO Box 94661 Folsom & W Prospector Place
Lincoln NE 68509
WK: 402 479-5633
HM: 402 947-4131
CELL: 402 525-6536
Representing: State Corrections
Committee: Co-Infection

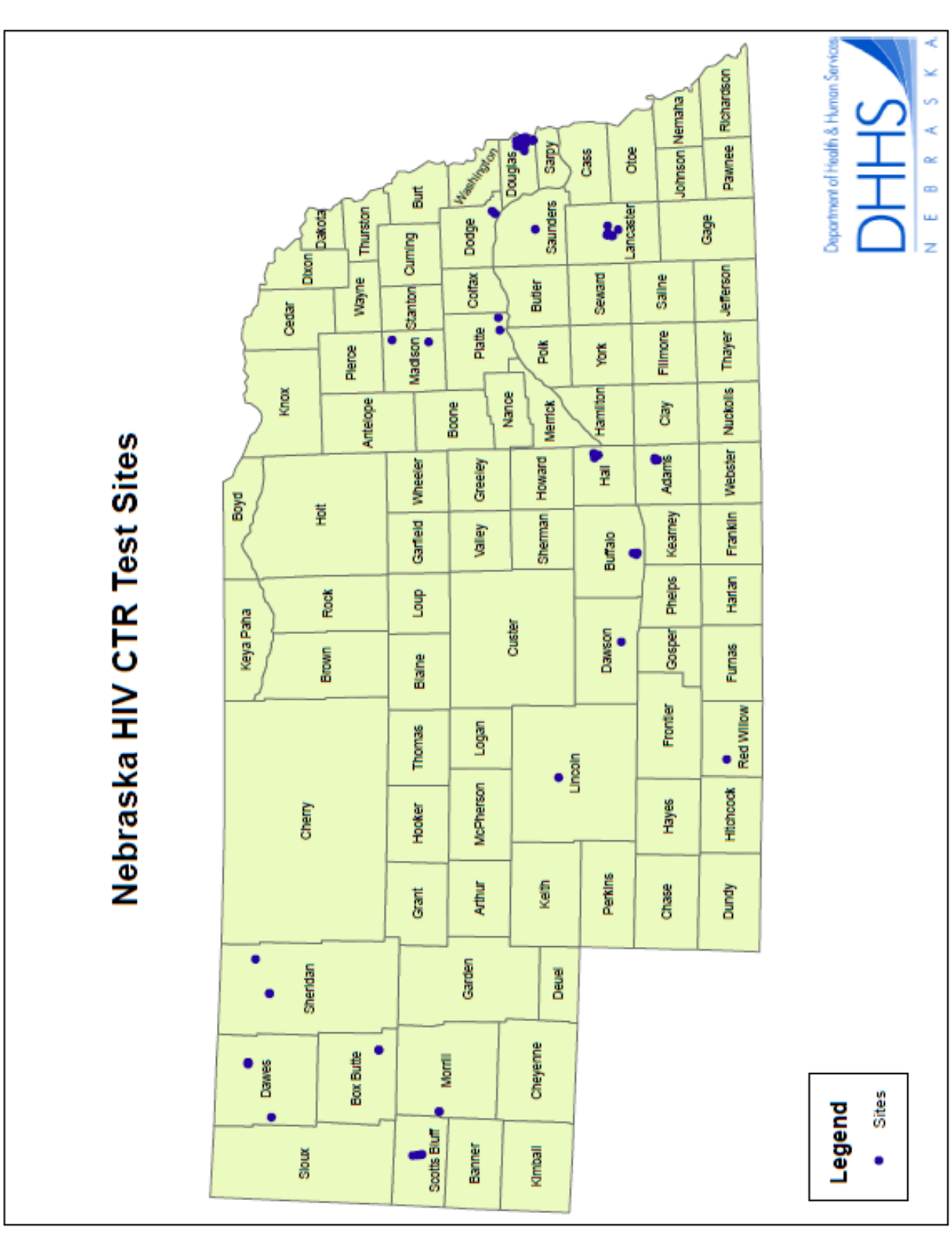
TRACY WEILAND
Lutheran Family Services
200 W 7th St, Box 3
Lexington NE 68850
WK: 308 324-6400
HM:
CELL:
Representing: Prevention Subgrantee
Committee: Membership

CINDY WHITE
3429 N 106th Plz, #921
Omaha NE 68134
WK:
HM: 402 551-5953
CELL:
Representing: Woman - HIV Impacted
Committee: Public Information

SHANNON WILLIAMS
Lincoln-Lancaster County Health Dept
3140 'N' St
Lincoln NE 68510
WK: 402 441-6243
HM: 402 464-8708
CELL: 402 310-4738
Representing: City/Cnty/District Hlth Dept
Committee: Interventions
Community Co-Chair

JILL YOUNG
Nebraska AIDS Project - Scottsbluff
4500 Avenue I PO Box 1500
Scottsbluff NE 69361
WK: 308 635-3807
HM: 308 220-4111
CELL: 308 637-7476
Representing: HIV Case Management
Committee: Care Services

Counseling and Testing Sites



Resource Directory